

Volume 48, Number 1  
Pages 1–112

January 3, 2023

# MISSOURI



# REGISTER

John R. Ashcroft  Secretary of State

The *Missouri Register* is an official publication of the state of Missouri, under the authority granted to the secretary of state by sections 536.015 and 536.033, RSMo. Reproduction of rules is allowed; however, no reproduction shall bear the name *Missouri Register* or “official” without the express permission of the secretary of state.

The *Missouri Register* is published semi-monthly by

**SECRETARY OF STATE**

**John R. Ashcroft**

**Administrative Rules Division**

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

**EDITOR-IN-CHIEF**

CURTIS W. TREAT

•

**MANAGING EDITOR**

STEPHANIE MARTIN

•

**PUBLICATION SPECIALIST II**

JACQUELINE D. WHITE

•

**EDITOR II**

VONNE KILBOURN

•

**EDITOR**

JENNIFER ALEX MOORE

•

**ADMINISTRATIVE AIDE III**

TAMMY WINKELMAN

ISSN 0149-2942

The *Missouri Register* and *Code of State Regulations* (CSR) are available on the Internet. The Register address is [sos.mo.gov/adrules/moreg/moreg](http://sos.mo.gov/adrules/moreg/moreg) and the CSR is [sos.mo.gov/adrules/csr/csr](http://sos.mo.gov/adrules/csr/csr). The Administrative Rules Division may be contacted by email at [rules@sos.mo.gov](mailto:rules@sos.mo.gov).

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.



## IN THIS ISSUE:

### EMERGENCY RULES

<b>Department of Health and Senior Services</b>	
Division of Regulation and Licensure .....	5
<b>Department of Commerce and Insurance</b>	
State Board of Registration for the Healing Arts.....	34

### EXECUTIVE ORDERS ..... 39

### PROPOSED RULES

<b>Office of Administration</b>	
Commissioner of Administration .....	40
<b>Department of Agriculture</b>	
Weights, Measures and Consumer Protection.....	41
<b>Department of Health and Senior Services</b>	
Division of Regulation and Licensure .....	44
Missouri Board of Nursing Home Administrators.....	86
<b>Department of Commerce and Insurance</b>	
Missouri State Board of Accountancy .....	86
State Board of Registration for the Healing Arts.....	91

### ORDERS OF RULEMAKING

<b>Department of Elementary and Secondary Education</b>	
Division of Learning Services .....	95
Office of Childhood .....	96
<b>Department of Health and Senior Services</b>	
Division of Regulation and Licensure .....	97
<b>Department of Commerce and Insurance</b>	
State Board of Registration for the Healing Arts.....	97
State Board of Pharmacy .....	97

### IN ADDITION

<b>Department of Health and Senior Services</b>	
Missouri Health Facilities Review Committee.....	99

### DISSOLUTIONS ..... 100

### SOURCE GUIDES

<b>RULE CHANGES SINCE UPDATE</b> .....	101
<b>EMERGENCY RULES IN EFFECT</b> .....	105
<b>EXECUTIVE ORDERS</b> .....	106
<b>REGISTER INDEX</b> .....	107

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
September 1, 2022 September 15, 2022	October 3, 2022 October 17, 2022	October 31, 2022 October 31, 2022	November 30, 2022 November 30, 2022
October 3, 2022 October 17, 2022	November 1, 2022 November 15, 2022	November 30, 2022 November 30, 2022	December 30, 2022 December 30, 2022
November 1, 2022 November 15, 2022	December 1, 2022 December 15, 2022	December 31, 2022 December 31, 2022	January 30, 2023 January 30, 2023
December 1, 2022 December 15, 2022	January 3, 2023 January 17, 2023	January 29, 2023 January 29, 2023	February 28, 2023 February 28, 2023
January 3, 2023 January 17, 2023	February 1, 2023 February 15, 2023	February 28, 2023 February 28, 2023	March 30, 2023 March 30, 2023
February 1, 2023 February 15, 2023	March 1, 2023 March 15, 2023	March 31, 2023 March 31, 2023	April 30, 2023 April 30, 2023
March 1, 2023 March 15, 2023	April 3, 2023 April 17, 2023	April 30, 2023 April 30, 2023	May 30, 2023 May 30, 2023
April 3, 2023 April 17, 2023	May 1, 2023 May 15, 2023	May 31, 2023 May 31, 2023	June 30, 2023 June 30, 2023

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please see the website at [sos.mo.gov/adrules/pubsched](https://sos.mo.gov/adrules/pubsched).

## HOW TO CITE RULES AND RSMO

### RULES

The rules are codified in the *Code of State Regulations* in this system—

<b>Title</b>	<b>CSR</b>	<b>Division</b>	<b>Chapter</b>	<b>Rule</b>
3	<i>Code of</i>	10-	4	115
Department	<i>State</i>	Agency	General area	Specific area
	<i>Regulations</i>	division	regulated	regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation; for example, 3 CSR 10-4.115, NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

### ***Code and Register on the Internet***

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is [sos.mo.gov/adrules/csr/csr](http://sos.mo.gov/adrules/csr/csr)

The *Register* address is [sos.mo.gov/adrules/moreg/moreg](http://sos.mo.gov/adrules/moreg/moreg)

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the Missouri and the United States Constitutions; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) business days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the Missouri Register as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

#### **EMERGENCY AMENDMENT**

**19 CSR 30-40.410 Definitions and Abbreviations Relating to Trauma Centers.** The department is amending section (1).

*PURPOSE:* This amendment adds virtual reviews to the definitions for trauma centers.

*EMERGENCY STATEMENT:* This emergency amendment adds virtual reviews to the definitions for trauma centers. This amendment was prompted by the passage of House Bill 2331 that passed during the 2022 legislative session. House Bill 2331 made changes to section 190.241, RSMo and allows the department to conduct virtual reviews rather than only on-site reviews of trauma centers. This emergency amendment is necessary in order to make this rule consistent with the changes made in House Bill 2331 that became effective on August 28, 2022. This emergency amendment is in the interest of both the hospitals and the department. The emergency amendment is necessary for the department to conduct virtual reviews instead of only on-site reviews. Due to complications caused by COVID-19, the department is having a difficult time getting qualified contractors to review the trauma

centers and hospitals are still being challenged with COVID-19 in their hospitals. National certifying bodies began using virtual reviews during the COVID-19 pandemic and these virtual reviews have proven to be a solution to conducting reviews while COVID-19 is still an issue for out-of-state – qualified contractors traveling to these reviews and for hospitals having to handle a review team in their hospitals. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires June 4, 2023.

(1) The following definitions and abbreviations shall be used in the interpretation of the rules in 19 CSR 30-40.400 to 19 CSR 30-40.450:

**(KK) Virtual review-** a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.

*AUTHORITY:* section 190.185, RSMo [Supp. 2007] 2016, and section 190.241, [HB 1790, 94th General Assembly, Second Regular Session, 2008] RSMo Supp. 2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed Jan. 16, 2007, effective Aug. 30, 2007. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

*PUBLIC COST:* This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.

*PRIVATE COST:* This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

#### **EMERGENCY AMENDMENT**

**19 CSR 30-40.420 Trauma Center Designation Requirements.** The department is amending sections (2) and (3) and renumbering throughout sections (2) and (3), and amending the application for trauma center designation form.

*PURPOSE:* This amendment decreases validation reviews to every three (3) years, adds virtual review requirements, updates language to be consistent with House Bill 2331 amendment, adds a requirement that hospitals must provide the department with required medical records and quality improvement documentation or be revoked, changes the requirements for hospitals participating in local and regional emergency medical services systems, updates what the hospitals have to submit to the department to

confirm verification or certification with national certifying bodies and when to submit changes of this verification or certification, and removes the data submission requirement. This amendment also makes changes to the application for trauma center designation form included herein in section (3)(A) changing the certification section to reflect the new requirements for notification of changes and participation in local and regional emergency medical services systems and removing the data submission requirement.

**EMERGENCY STATEMENT:** This emergency amendment makes several updates to this rule that were prompted by the passage of House Bill (HB) 2331 during the 2022 legislative session. HB 2331 made changes to sections 190.241 and 190.245, RSMo. These changes became effective on August 28, 2022. HB 2331 requires trauma centers to be reviewed by the department every three (3) years. House Bill 2331 also allows the department to conduct virtual reviews rather than only on-site reviews of these stroke centers. HB 2331 added a requirement for hospitals to provide the department with quality improvement documentation necessary for the department to conduct a trauma review or the hospital's trauma center designation will be revoked. Finally, HB 2331 made changes about how hospitals, which are verified or certified by national certifying bodies designated by the department, need to report changes of their verification or certification to the department and how these hospitals participate in local and regional emergency medical services systems. This emergency amendment is necessary in order to make this rule consistent with the changes made in HB 2331 that became effective on August 28, 2022. This emergency amendment is in the interest of both the hospitals and the department to ensure that hospitals, which are applying for designation with the department because they are certified or verified by a department approved national designating body, do not have to provide the department with any additional information than what is now required by the changes made to section 190.241, RSMo by HB 2331. Finally, the emergency amendment is necessary for the department to conduct virtual reviews instead of only on-site reviews. Due to complications caused by COVID-19, the department is having a difficult time in getting qualified contractors to review the trauma centers and hospitals are still being challenged with COVID-19 in their hospitals. National certifying bodies began using virtual reviews during the COVID-19 pandemic and these virtual reviews have proven to be a solution to conducting reviews while COVID-19 is still an issue for out-of-state-qualified contractors traveling to these reviews and for hospitals having to handle a review team in their hospitals. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri and United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires June 4, 2023.

(2) Hospitals requesting to be reviewed and designated as a trauma center by the department shall meet the following requirements:

(F) The review of hospitals for trauma center designation shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **The department may conduct an onsite review, a virtual review or a combination thereof on the hospitals/trauma centers. For announced reviews that are scheduled with the hospitals/**

**trauma centers, the department will make the hospitals/trauma centers aware at least thirty (30) days prior to the scheduled review whether the department intends that the review will be conducted onsite and/or virtually. Due to unforeseen circumstances, the department may need to change whether the review is conducted onsite and/or virtually less than thirty (30) days before the announced review. The department will contact the hospitals/trauma centers to make the hospitals/trauma centers aware of any changes about how the review will be conducted, either onsite and/or virtually, prior to the date of the announced review. The cost of any and all site reviews shall be paid by each applicant hospital or renewing trauma center unless adequate funding is available to the department to pay for reviews;**

(J) Validation reviews shall occur every *[five (5)]* three (3) years;

(K) Hospitals/Trauma centers being reviewed through a virtual survey shall do the following:

1. Provide a videoconferencing platform to be used for the hospital/trauma center virtual review;

2. Provide a live tour of the hospital;

3. Ensure the videoconferencing platform used during the review is compliant with state and federal laws for protected health information;

4. Assign an onsite visit coordinator for the review. The onsite visit coordinator role cannot be fulfilled by the trauma program manager. This onsite visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:

A. Scheduling the videoconferencing meetings;

B. Sending out calendar invitations;

C. Providing Electronic Medical Record (EMR) access to designated individuals;

D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and

E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors and the department;

5. Assign one staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the trauma program manager, the trauma program medical director, the trauma program registrar or the onsite visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR;

6. Provide the department with requested patient care report information for the review no later than thirty (30) days prior to the virtual review;

7. Provide the department with requested medical records, PIPS documentation, registry report and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;

8. Schedule a prereview call with the qualified contractors, the department, the trauma program medical director, the trauma program manager, the staff navigators and the onsite visit coordinator approximately one (1) week prior to the virtual review;

9. Test the functionality of the videoconferencing platform for the live tour of the hospital prior to the prereview call; and

10. Provide a list of attendees for the review meeting and their roles to the review team and the department prior to the virtual review.

(L) The department may conduct an on-site review of the hospital prior to the virtual review to ensure that the hospital

**meets the requirements for trauma center designation;**

**[(K)](M)** Upon completion of a review, the reviewers shall submit a report of their findings to the department. The report shall state whether the specific standards for trauma center designation have or have not been met; if not met, in what way they were not met. The report shall include the patient chart audits and a narrative summary to include pre-hospital, hospital, trauma service, emergency department, operating room, recovery room, clinical lab, intensive care unit, blood bank, rehabilitation, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department has final authority to determine compliance with the rules of this chapter;

**[(L)](N)** Within thirty (30) days after receiving a review report, the department shall return a copy of the report in whole to the chief executive officer of the hospital reviewed. Included with the report shall be notification indicating that the hospital has met the criteria for trauma center designation or has failed to meet the criteria for the designation level for which it applied and options the hospital may pursue;

**[(M)](O)** If a verification review is required, the hospital shall be allowed a period of six (6) months to correct deficiencies. A plan of correction form shall be provided to the department and shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings;

**[(N)](P)** Once a review is completed, a final report shall be prepared by the department. The final report shall be public record and shall disclose the standards by which the reviews were conducted and whether the standards were met. The reports filed by the reviewers shall be held confidential and shall be disclosed only to the hospital's chief executive officer or an authorized representative;

**[(O)](Q)** The department shall have the authority to put on probation, suspend, revoke, or deny trauma center designation if *[there is reasonable cause to believe]* **the department has determined** that there has been a substantial failure to comply with the requirements of the rules in this chapter. Once designated as a trauma center, a hospital may voluntarily surrender the designation at any time without giving cause, by contacting the department. In these cases, the application and review process shall be completed again before the designation may be reinstated;

**[(P)](R)** Trauma center designation shall be valid for a period of *[five (5)]* **three (3)** years from the date the trauma center is designated. Expiration of the designation shall occur unless the trauma center applies for validation review within this *[five- (5-)]* **three- (3-)** year period. Trauma center designation shall be site specific and not transferable when a trauma center changes location; and

**[(Q)](S)** The department shall investigate complaints against trauma centers. Failure of the hospital to cooperate in providing documentation and interviews with appropriate staff may result in revocation of trauma center designation. Any hospital, which takes adverse action toward an employee for cooperating with the department regarding a complaint, is subject to revocation of trauma center designation.

**(T) Failure of a hospital/trauma center to provide all medical records and quality improvement documentation necessary for the department to conduct a trauma review in order to determine if the requirements of 19 CSR 30-40.430 have been met shall result in the revocation of the hospital/trauma center's designation as a trauma center.**

(3) Hospitals seeking trauma center designation by the department based on their current verification as a trauma center by the American College of Surgeons shall meet the following requirements:

*[(C) Annually from the date of designation by the department submit to the department proof of verification as a trauma center by the American College of Surgeons and the names and contact information of the medical director of the trauma center and the program manager of the trauma center;]*

**[(D)](C)** Within thirty (30) days of any changes **or receipt of a verification, the hospital shall** submit to the department proof of verification as a trauma center by the American College of Surgeons and the names and contact information of the medical director of the trauma center and the program manager of the trauma center. **Verification as a trauma center by the American College of Surgeons shall accompany the application for trauma verified hospital designation form. A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is verified as a trauma center by the American College of Surgeons for which the hospital used to receive its corresponding designation with the department as a trauma center, whether because the hospital voluntarily surrendered this verification, or because the hospital's verification was suspended or revoked by the American College of Surgeons or expired;**

*[(E) Submit to the department a copy of the verifying organization's final trauma center verification survey results within thirty (30) days of receiving such results;*

*[(F) Submit to the department a completed application for trauma verified hospital designation form every three (3) years;*

*[(G) Participate in the emergency medical services regional system of trauma care in its respective emergency medical services region as defined in 19 CSR 30-40.302;]*

**[(H)](D)** Participate in local and regional emergency medical services systems *[by reviewing and sharing outcome data and]* **for purposes of** providing training, *[and]* **sharing** clinical educational resources, **and collaborating on improving patient outcomes;**

*[(I) Submit data to meet the data submission requirements in 19 CSR 30-40.430;]*

**[(J)](E)** The designation of a hospital as a trauma center pursuant to section (3) shall continue if such hospital retains verification as a trauma center by the American College of Surgeons; and

**[(K)](F)** The department may remove a hospital's designation as a trauma center if requested by the hospital or the department determines that the verification by the American College of Surgeons has been suspended or revoked. The department may also remove a hospital's designation as a trauma center if the department determines the hospital's verification with the American College of Surgeons has expired. Any decision made by the department to withdraw the designation of a trauma center that is based on the revocation or suspension of a verification by the American College of Surgeons shall not be subject to judicial review.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION OF HEALTH STANDARDS AND LICENSURE  
**APPLICATION FOR TRAUMA VERIFIED HOSPITAL DESIGNATION**

In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a trauma center. Please complete all information.		Organization's Trauma Identification Number	
<b>CURRENT TRAUMA VERIFICATION ORGANIZATION AND LEVEL</b>			
<p style="text-align: center;"><b>ADULT AND PEDIATRIC (TREATS ADULTS AND CHILDREN)</b></p> <p><input type="checkbox"/> Level I Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level II Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level III Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level IV Trauma Center by the American College of Surgeons</p>	<p style="text-align: center;"><b>PEDIATRIC (TREATS CHILDREN ONLY)</b></p> <p><input type="checkbox"/> Level I Pediatric Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level II Pediatric Trauma Center by the American College of Surgeons</p>	<p style="text-align: center;"><b>ADULT (TREATS ADULTS ONLY)</b></p> <p><input type="checkbox"/> Level I Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level II Trauma Center by the American College of Surgeons</p>	
<b>HOSPITAL INFORMATION</b>			
Name of Hospital (Name to Appear on Designation Certificate)			Telephone Number
Address (Street and Number)	City	Zip Code	
<b>PROFESSIONAL INFORMATION</b>			
Chief Executive Officer		Chairman/President of Board of Trustees	
Trauma Medical Director (Name, email, and contact phone number)		Trauma Program Manager (Name, email, and contact phone number)	
<b>The following should be submitted to the department as indicated:</b>			
<input type="checkbox"/> Proof of trauma verification with the American College of Surgeons with the expiration date of the verification.			
<b>CERTIFICATION</b>			
<p>We, the undersigned, hereby certify that:</p> <p>A. Within thirty (30) days of any changes or receipt of a verification, we will submit to the department proof of trauma verification with the American College of Surgeons.</p> <p>B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of our trauma center.</p> <p>C. Within thirty (30) days of the date that our hospital is no longer verified by the American College of Surgeons, whether because we voluntarily surrendered our verification or because our verification has been suspended or revoked by the American College of Surgeons or has expired, we will report this change in writing to the department.</p> <p>D. We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes.</p> <p>E. We understand that our designation as a trauma center by the department shall continue only if our hospital remains verified as a trauma center by the American College of Surgeons.</p>			
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Date of application _____</p> <p>Signed _____ Chairman/President of Board of Trustees, Owner, or one Partner of Partnership</p> <p>Signed _____ Trauma Medical Director</p> </div> <div style="width: 45%;"> <p>Signed _____ Hospital Chief Executive Officer</p> <p>Signed _____ Director of Emergency Medicine</p> </div> </div>			

*AUTHORITY: section[s 190.176 and] 190.185, RSMo 2016, and sections **190.176 and** 190.241, RSMo Supp. [2017]2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Emergency amendment filed Feb. 2, 2018, effective Feb. 12, 2018, expired Aug. 10, 2018. Amended: Filed Feb. 2, 2018, effective Aug. 30, 2018. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.*

*PRIVATE COST: This emergency amendment will cost private entities one thousand dollars (\$1,000) in the time the emergency is effective.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Department of Health and Senior Services**  
**Division Title: Division of Regulation and Licensure**  
**Chapter Title: 19 CSR 30-40.420 Trauma Center Designation Requirements.**

<b>Rule Number and Title:</b>	<b>19 CSR 30-40.420 Trauma Center Designation Requirements</b>
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Four (4) hospitals/trauma centers	\$1,000 in the time the emergency is effective
<b>TOTAL COSTS =</b>	<b>\$1,000 in the time the emergency is effective</b>

**III. WORKSHEET**

Four (4) private hospitals/trauma centers reviewed during the time that the emergency amendment is effective X \$250.00 = \$1,000 for the hospitals/trauma centers reviewed during the time that the emergency amendment is effective.

**IV. ASSUMPTIONS**

There are currently twenty-two (22) Level I-III trauma centers designated with the department. The department anticipates that four (4) private hospitals/trauma centers will be reviewed during the time the emergency amendment is effective.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.720 will cost hospitals/trauma centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

**TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 30 – Division of Regulation and Licensure  
Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

**EMERGENCY AMENDMENT**

**19 CSR 30-40.430 Standards for Trauma Center Designation.**  
The department is amending sections (1), (3) and (4) and renumbering throughout section (1).

*PURPOSE: This amendment changes continuing education hours to be consistent with required continuing education requirements by the national verifying body for trauma centers, removes continuing medical education requirements for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine and who are practicing in the emergency department of a trauma center, and adds an option for trauma centers to enter trauma data into a national data registry or databank that will allow the trauma center to perform its performance improvement and patient safety program requirements.*

*EMERGENCY STATEMENT: This emergency amendment makes several updates to this rule that were prompted by the passage of House Bill 2331 which passed during the 2022 legislative session. House Bill 2331 made changes to section 190.241, RSMo. House Bill 2331 prohibits the department from requiring physicians, nurses and other providers at trauma centers from being required to obtain continuing education on trauma for any more than what is required by the national verification body of trauma centers. House Bill 2331 also prohibits the department from requiring physicians to obtain continuing education on trauma for those physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department of a trauma center. Finally, House Bill 2331 allows the trauma centers to enter trauma data into a national data registry or national databank that still allows them to meet the performance improvement and patient safety program requirements for trauma centers. This emergency amendment is in the interest of both the hospitals and the department to make all parties aware of how many continuing education hours on trauma that hospital staff are required to have during trauma reviews based on the changes made to section 190.241, RSMo. This emergency amendment is also needed in order to allow trauma centers to enter trauma data into a national data registry or national data bank that they are already using and not have to transfer the data or manually enter data into the department's trauma registry in order to save staff time. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires June 4, 2023.*

(1) General Standards for Trauma Center Designation.

(E) The hospital shall appoint a board-certified surgeon to serve as the trauma medical director. (I-R, II-R, III-R)

1. There shall be a job description and organization chart

depicting the relationship between the trauma medical director and other services. (I-R, II-R, III-R)

2. The trauma medical director shall be a member of the surgical trauma call roster. (I-R, II-R, III-R)

3. The trauma medical director shall be responsible for the oversight of the education and training of the medical and nursing staff in trauma care. (I-R, II-R, III-R)

4. The trauma medical director shall document *[a minimum average of sixteen (16)] thirty-six (36)* hours of continuing medical education (CME) in trauma care every **three (3)** years. (I-R, II-R, III-R)

5. The trauma medical director shall participate in the trauma center's research and publication projects. (I-R)

(F) There shall be a trauma nurse coordinator/trauma program manager. (I-R, II-R, III-R)

1. There shall be a job description and organization chart depicting the relationship between the trauma nurse coordinator/trauma program manager and other services. (I-R, II-R, III-R)

2. The trauma nurse coordinator/trauma program manager shall document *[a minimum average of sixteen (16)] thirty-six (36)* hours of continuing nursing education in trauma care every **three (3)** years. (I-R, II-R, III-R)

*[(H)] All members of the surgical trauma call roster and emergency medicine physicians including liaisons for anesthesiology, neurosurgery, and orthopedic surgery shall document a minimum average of eight (8) hours of CME in trauma care every year. In hospitals designated as adult/pediatric trauma centers, providing care to injured children fourteen (14) years of age and younger, four (4) of the eight (8) hours of education per year must be applicable to pediatric trauma. (I-R, II-R, III-R)]*

*[(I)](H) The hospital shall demonstrate that there is a plan for adequate post-discharge follow-up on trauma patients, including rehabilitation. (I-R, II-R, III-R)*

*[(J)](I) A [Missouri] trauma registry shall be completed on each patient who sustains a traumatic injury and meets the following criteria: Includes at least one (1) code within the range of the following injury diagnostic codes as defined in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9)-(CM) 800-959.9 which is incorporated by reference in this rule as published by the Centers for Disease Control and Prevention in 2006 and is available at National Center for Health Statistics, 1600 Clifton Road, Atlanta, GA 30333. This rule does not incorporate any subsequent amendments or additions. Excludes all diagnostic codes within the following code ranges: 905–909.9 (late effects of injury), 910–924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites), 930–939.9 (foreign bodies), and must include one (1) of the following criteria: hospital admission, patient transfer out of facility, or death resulting from the traumatic injury (independent of hospital admission or hospital transfer status). [The registry shall be submitted electronically in a format defined by the Department of Health and Senior Services. Electronic data shall be submitted quarterly, ninety (90) days after the quarter ends. The trauma registry must be current and complete. A patient log with admission date, patient name, and injuries must be available for use during the site review process. Information provided by hospitals on the trauma registry shall be subject to the same confidentiality requirements and procedures contained in section 192.067, RSMo. The trauma care data elements shall be those identified and defined by the National Trauma Data Standard which is incorporated by reference in this rule as published by the American College of Surgeons in 2008 and is available at the American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)]*

Trauma centers shall enter trauma care data elements for each patient who meets these criteria. The trauma care data elements shall be those identified and defined by the National Trauma Data Standard which is incorporated by reference in this rule as published by the American College of Surgeons in 2008 and is available at the American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)

1. Trauma centers shall enter trauma care data elements for each patient who meets the criteria above into the following:

A. Trauma centers shall submit data into the department's Missouri trauma registry. The data required in paragraph (1)(I) above shall be submitted electronically into the Missouri trauma registry via the department's website at [www.health.mo.gov](http://www.health.mo.gov); or (I-R, II-R, III-R)

B. Trauma centers shall submit data into a national data registry or data bank capable of being used by the trauma center to perform its ongoing performance improvement and patient safety program requirements for its trauma patients. (I-R, II-R, III-R)

2. Electronic data shall be submitted quarterly, ninety (90) days after the quarter ends. The trauma registry must be current and complete. (I-R, II-R, III-R)

3. Information provided by hospitals on the trauma registry shall be subject to the same confidentiality requirements and procedures contained in section 192.067, RSMo. (I-R, II-R, III-R)

(J) A patient log of those patients entered into the trauma registry with admission date, patient name, and injuries must be available for use during the site review process. (I-R, II-R, III-R)

(3) Standards for Special Facilities/Re-sources/Capabilities for Trauma Center Designation.

(A) The hospital shall meet emergency department standards for trauma center designation.

1. The emergency department staffing shall ensure immediate and appropriate care of the trauma patient. (I-R, II-R, III-R)

A. The physician director of the emergency department shall be board-certified or board-admissible in emergency medicine. (I-R, II-R)

B. There shall be a physician trained in the care of the critically injured as evidenced by credentialing in ATLS *[and current in trauma CME]* in the emergency department twenty-four (24) hours a day. ATLS is incorporated by reference in this rule as published by the American College of Surgeons in 2003 and is available at American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)

C. All emergency department physicians shall be certified in ATLS at least once. Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status. (I-R, II-R, III-R)

D. There shall be written protocols defining the relationship of the emergency department physicians to other physician members of the trauma team. (I-R, II-R, III-R)

E. All registered nurses assigned to the emergency department shall be credentialed in trauma nursing by the hospital within one (1) year of assignment. (I-R, II-R, III-R)

*[(I) Registered nurses credentialed in trauma nursing shall document a minimum of eight (8) hours of trauma-related continuing nursing education per year. (I-R, II-R, III-R)]*

*[(II)(I) Registered nurses credentialed in trauma care shall maintain current provider status in the Trauma*

Nurse Core Curriculum or Advanced Trauma Care for Nurses and either Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS), or Emergency Nursing Pediatric Course (ENPC) within one (1) year of employment in the emergency department. The requirement for Pediatric Advanced Life Support, Advanced Pediatric Life Support, or Emergency Nursing Pediatric Course may be waived in centers where policy exists diverting injured children to a pediatric trauma center and where a pediatric trauma center is adjacent and a performance improvement filter reviewing any children seen is maintained. The Trauma Nurse Core Curriculum is incorporated by reference in this rule as published in 2007 by the Emergency Nurses Association and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. Advanced Trauma Care for Nurses is incorporated by reference in this rule as published in 2003 by the Society of Trauma Nurses and is available at the Society of Trauma Nurses, 1926 Waukegan Road, Suite 100, Glenview, IL 60025. This rule does not incorporate any subsequent amendments or additions. Pediatric Advanced Life Support is incorporated by reference in this rule as published in 2005 by the American Heart Association and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. The Emergency Nursing Pediatric Course is incorporated by reference in this rule as published by the Emergency Nurses Association in 2004 and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)

2. Equipment for resuscitation and life support with age appropriate sizes for the critically or seriously injured shall include the following:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, sources of oxygen, and mechanical ventilator—I-R, II-R, III-R;

B. Suction devices—I-R, II-R, III-R;

C. Electrocardiograph, cardiac monitor, and defibrillator—I-R, II-R, III-R;

D. Central line insertion equipment—I-R, II-R, III-R;

E. All standard intravenous fluids and administration devices including intravenous catheters—I-R, II-R, III-R;

F. Sterile surgical sets for procedures standard for the emergency department—I-R, II-R, III-R;

G. Gastric lavage equipment—I-R, II-R, III-R;

H. Drugs and supplies necessary for emergency care—I-R, II-R, III-R;

I. Two-way radio linked with emergency medical service (EMS) vehicles—I-R, II-R, III-R;

J. End-tidal carbon dioxide monitor—I-R, II-R, III-R and mechanical ventilators—I-R, II-R;

K. Temperature control devices for patient, parenteral fluids, and blood—I-R, II-R, III-R; and

L. Rapid infusion system for parenteral infusion—I-R, II-R, III-R.

3. There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-R)

4. There shall be a designated trauma resuscitation area in the emergency department. (I-R, II-R)

5. There shall be X-ray capability with twenty-four (24)-hour coverage by technicians. (I-IH, II-IH, III-IA)

6. Nursing documentation for the trauma patient shall be on a trauma flow sheet approved by the trauma medical director and trauma nurse coordinator/trauma program manager. (I-R, II-R, III-R)

(B) The hospital shall meet intensive care unit (ICU) standards

for trauma center designation.

1. There shall be a designated surgeon medical director for the ICU. (I-R, II-R, III-R)

2. A physician who is not the emergency department physician shall be on duty in the ICU or available in-house twenty-four (24) hours a day in a level I trauma center and shall be on call and available within twenty (20) minutes in a level II trauma center.

3. The minimum registered nurse/trauma patient ratio used shall be one to two (1:2). (I-R, II-R, III-R)

4. Registered nurses shall be credentialed in trauma care within one (1) year of assignment. *[documenting a minimum of eight (8) hours of trauma-related continuing nursing education per year.]* (I-R, II-R, III-R)

5. Nursing care documentation shall be on a patient flow sheet. (I-R, II-R, III-R)

6. At the time of the initial review, nurses assigned to ICU shall have successfully completed or be registered for a provider ACLS course. The requirement for ACLS may be waived in pediatric centers where policy exists diverting injured adults to an adult trauma center and where an adult trauma center is adjacent to the affected pediatric facilities, and a performance improvement filter reviewing any adult trauma patients seen is maintained (I-R, II-R, III-R).

7. There shall be separate pediatric and adult ICUs or a combined ICU with nurses trained in pediatric intensive care. In ICUs providing care to children, registered nurses shall maintain credentialing in PALS, APLS, or ENPC (I-R, II-R)

8. There shall be beds for trauma patients or comparable level of care provided until space is available in ICU. (I-R, II-R, III-R)

9. Equipment for resuscitation and to provide life support for the critically or seriously injured shall be available for the intensive care unit. In ICUs providing care for the pediatric patient, equipment with age appropriate sizes shall also be available. This equipment shall include, but not be limited to:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, and a mechanical ventilator – I-R, II-R, III-R;

B. Oxygen source with concentration controls – I-R, II-R, III-R;

C. Cardiac emergency cart, including medications – I-R, II-R, III-R;

D. Temporary transvenous pacemakers – I-R, II-R, III-R;

E. Electrocardiograph, cardiac monitor, and defibrillator – I-R, II-R, III-R;

F. Cardiac output monitoring – I-R, II-R;

G. Electronic pressure monitoring and pulse oximetry – I-R, II-R;

H. End-tidal carbon dioxide monitor and mechanical ventilators – I-R, II-R, III-R;

I. Patient weighing devices – I-R, II-R, III-R;

J. Temperature control devices – I-R, II-R, III-R;

K. Drugs, intravenous fluids, and supplies – I-R, II-R, III-R; and

L. Intracranial pressure monitoring devices – I-R, II-R.

10. There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-R)

(4) Standards for Programs in Performance Improvement and Improvement Patient Safety Program, Outreach, Public Education, and Training for Trauma Center Designation.

(F) There shall be a hospital-approved procedure for credentialing nurses in trauma care. (I-R, II-R, III-R)

1. All nurses providing care to severely injured patients and assigned to the emergency department or ICU shall complete a *[minimum of sixteen (16) hours of]* trauma nursing course[s] in order to become credentialed in trauma care. (I-R,

II-R, III-R)

2. The content and format of any trauma nursing courses developed and offered by a hospital shall be developed in cooperation with the trauma medical director. A copy of the course curriculum used shall be filed with the EMS Bureau. (I-R, II-R, III-R)

3. Trauma nursing courses offered by institutions of higher education in Missouri such as the Advanced Trauma Care for Nurses, Emergency Nursing Pediatric Course, or the Trauma Nurse Core Curriculum may be used to fulfill this requirement. To receive credit for this course, a nurse shall obtain advance approval for the course from the trauma medical director and trauma nurse coordinator/trauma program manager and shall present evidence of satisfactory completion of the course. (I-R, II-R, III-R)

*AUTHORITY: section 190.185, RSMo [Supp. 2007] 2016, and section 190.241, [HB 1790, 94th General Assembly, Second Regular Session, 2008] RSMo Supp. 2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed Jan. 16, 2007, effective Aug. 30, 2007. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the Missouri Register.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.*

*PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.*

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

#### **EMERGENCY AMENDMENT**

**19 CSR 30-40.710 Definitions and Abbreviations Relating to Stroke Centers.** The department is amending section (1).

*PURPOSE: This amendment adds virtual reviews to the definitions for stroke centers.*

*EMERGENCY STATEMENT: This emergency amendment adds virtual reviews to the definitions for stroke centers. This amendment was prompted by the passage of House Bill 2331 that passed during the 2022 legislative session. House Bill 2331 made changes to section 190.241, RSMo and allows the department to conduct virtual reviews rather than only on-site reviews of stroke centers. This emergency amendment is necessary in order to make this rule consistent with the changes made in House Bill 2331 that became effective on August 28, 2022. This emergency amendment is in the interest of both the hospitals and the department. The emergency amendment is necessary for the department to conduct virtual reviews instead of only on-site reviews. Due to complications caused by COVID-19, the department is having a difficult time getting qualified contractors to review the stroke centers and hospitals are still being challenged with COVID-19 in their hospitals. National certifying bodies began using virtual reviews during the COVID-19 pandemic and these virtual reviews have proven to be a solution to conducting reviews while*

COVID-19 is still an issue for out-of-state- qualified contractors traveling to these reviews and for hospitals having to handle a review team in their hospitals. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri and United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires June 4, 2023.

(1) As used in 19 CSR 30-40.720 and 19 CSR 30-40.730, the following terms shall mean:

**(XX) Virtual review- a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.**

**AUTHORITY:** sections 192.006 **and 190.185**, RSMo [2000] 2016, and section[s] 190.185 and] 190.241, RSMo Supp. [2012] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

**PUBLIC COST:** This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.

**PRIVATE COST:** This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

#### **EMERGENCY AMENDMENT**

**19 CSR 30-40.720 Stroke Center Designation Application and Review.** The department is amending sections (2) and (3) and renumbering throughout sections (2) and (3), and amending the application for stroke center designation form.

**PURPOSE:** This amendment decreases validation reviews to every three (3) years, adds virtual review requirements, clarifies honorarium and payment requirements for virtual reviews, adds a requirement that hospitals must provide the department with required medical records and quality improvement documentation or be revoked, updates language to be consistent with HB 2331 amendment, changes the requirements for hospitals participating in local and regional emergency medical services system, removes the data submission requirement for hospitals verified or certified by department approved national certifying bodies, and updates what the hospitals have to submit to the department to confirm verification or certification with national certifying bodies and when to submit changes of this verification or certification. This amendment also makes changes to the application for stroke center designation form included herein in section (3)(A) by changing the certification section to reflect the new requirements for notification of changes and participation in local and regional emergency medical services systems and

removing the data submission requirement.

**EMERGENCY STATEMENT:** This emergency amendment makes several updates to this rule that were prompted by the passage of House Bill 2331 that passed during the 2022 legislative session. House Bill 2331 made changes to sections 190.241 and 190.245, RSMo. House Bill 2331 requires stroke centers to be reviewed by the department every three (3) years. House Bill 2331 also allows the department to conduct virtual reviews rather than only on-site reviews of these stroke centers. House Bill 2331 added a requirement for hospitals to provide the department with quality improvement documentation necessary for the department to conduct a stroke review or the hospital's stroke center designation will be revoked. Finally, House Bill 2331 made changes about how hospitals which are verified or certified by national certifying bodies designated by the department need to report changes of their verification or certification to the department and how these hospitals participate in local and regional emergency medical services systems. This emergency amendment is necessary in order to make this rule consistent with the changes made in House Bill 2331 that became effective on August 28, 2022. This emergency amendment is in the interest of both the hospitals and the department to ensure that hospitals which are applying for designation with the department because they are certified or verified by a department approved national designating body do not have to provide the department with any additional information than what is now required by the changes made to section 190.241, RSMo by HB 2331. Finally, the emergency amendment is necessary for the department to conduct virtual reviews instead of only on-site reviews. Due to complications caused by COVID-19, the department is having a difficult time in getting qualified contractors to review the stroke centers and hospitals are still being challenged with COVID-19 in their hospitals. National certifying bodies began using virtual reviews during the COVID-19 pandemic and these virtual reviews have proven to be a solution to conducting reviews while COVID-19 is still an issue for out-of-state- qualified contractors traveling to these reviews and for hospitals having to handle a review team in their hospitals. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri and United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires June 4, 2023.

(2) Hospitals requesting to be reviewed and designated as a stroke center by the department shall meet the following requirements:

(D) **The department may conduct an onsite review, a virtual review or a combination thereof on the hospitals/stroke centers. For announced reviews that are scheduled with the hospitals/stroke centers, the department will make the hospitals/stroke centers aware at least thirty (30) days prior to the scheduled review whether the department intends that the review will be conducted onsite and/or virtually. Due to unforeseen circumstances, the department may need to change whether the review is conducted onsite and/or virtually less than thirty (30) days before the announced review. The department will contact the hospitals/stroke centers to make the hospitals/stroke centers aware of any changes about how the review will be conducted, either onsite and/or virtually, prior to the date of the announced review.** The different types

of *[site]* reviews to be conducted on hospitals/stroke centers seeking stroke center designation by the department include:

1. An initial review shall occur on a hospital applying to be initially designated as a stroke center. An initial review shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **This review may occur onsite and/or virtually;**

2. A validation review shall occur on a designated stroke center applying for renewal of its designation as a stroke center. Validation reviews shall occur no less than every *[four (4)] three (3)* years. A validation review shall include interviews with designated stroke center staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **This review may occur onsite and/or virtually;** and

3. A focus review shall occur on a designated stroke center in which an initial or validation review was conducted and substantial deficiency(ies) were cited. A review of the physical plant will not be necessary unless a deficiency(ies) was cited in the physical plant in the preceding validation review. The focus review team shall be comprised of a representative from the department and may include a qualified contractor(s) with the required expertise to evaluate corrections in areas where deficiencies were cited. **This review may occur onsite and/or virtually;**

(E) Stroke center designation shall be valid for a period of *[four (4)] three (3)* years from the date the stroke center/hospital is designated.

1. Stroke center designation shall be site specific and non-transferable when a stroke center changes location.

2. Once designated as a stroke center, a stroke center may voluntarily surrender the designation at any time without giving cause, by contacting the department in writing. In these cases, the application and review process shall be completed again before the designation may be reinstated;

(H) Hospitals/stroke centers shall be responsible for paying expenses related to the cost of the qualified contractors to review their respective hospitals/stroke centers during initial, validation, and focus reviews. The department shall be responsible for paying the expenses of its representative. Costs of the review to be paid by the hospital/stroke center include:

1. An honorarium shall be paid to each qualified contractor of the review team **whether the review occurs on-site or virtually.** Qualified contractors of the review team for levels I and II stroke center reviews shall be paid *[six hundred dollars (\$600) for the day of travel per reviewer and eight hundred fifty dollars (\$850) for the day of the review] one thousand four hundred fifty dollars (\$1,450)* per reviewer. Qualified contractors of the review team for levels III and IV stroke center reviews shall be paid *[five hundred dollars (\$500) for the day of travel per reviewer and five hundred dollars (\$500) for the day of the review] one thousand dollars (\$1,000)* per reviewer. This honorarium shall be paid to each qualified contractor of the review team at the time the site survey begins **if on-site or prior to the review beginning if the review is conducted virtually;**

2. Airfare shall be paid for each qualified contractor of the review team, if applicable;

3. Lodging shall be paid for each qualified contractor of the review team, **unless the review is conducted virtually.** The hospital/stroke center shall secure the appropriate number of hotel rooms for the qualified contractors and pay the hotel directly; and

4. Incidental expenses, if applicable, for each qualified contractor of the review team shall not exceed two hundred

fifty dollars (\$250) and may include the following:

- A. Airport parking;
- B. Checking bag charges;
- C. Meals during the review; and

D. Mileage to and from the review if no airfare was charged by the reviewer. **If the reviewer solely participated virtually in the review and did not travel by vehicle to the review, then no mileage shall be paid.** Mileage shall be paid at the federal mileage rate for business miles as set by the Internal Revenue Service (IRS). Federal mileage rates can be found at the website [www.irs.gov](http://www.irs.gov);

**(I) Hospitals/stroke centers being reviewed through a virtual review shall do the following:**

1. Provide a videoconferencing platform to be used for the hospital/stroke center virtual review;

2. Provide a live tour of the hospital;

3. Ensure the videoconferencing platform used during the review is compliant with state and federal laws for protected health information;

4. Assign an onsite visit coordinator for the review. The onsite visit coordinator role cannot be fulfilled by the stroke program manager. This onsite visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:

- A. Scheduling the videoconferencing meetings;
- B. Sending out calendar invitations;
- C. Providing Electronic Medical Record (EMR) access to designated individuals;

D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and

E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors and the department;

5. Assign one staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the stroke program manager, the stroke program medical director, the stroke program registrar or the onsite visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR;

6. Provide the department with requested patient care report information for the review through a method that is compliant with state and federal laws for protected health information no later than thirty (30) days prior to the virtual review;

7. Provide the department with requested medical records, PIPS documentation, registry report and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;

8. Schedule a pre-review call with the qualified contractors, the department, the stroke program medical director, the stroke program manager, the staff navigators and the onsite visit coordinator approximately one (1) week prior to the virtual review;

9. Test the functionality of the videoconferencing platform for the live tour of the hospital prior to the pre-review call; and

10. Provide a list of attendees for the review meeting and their roles to the review team and the department prior to the virtual review;

**(J) The department may conduct an on-site review of the hospital prior to the virtual review to ensure that the hospital meets the requirements for stroke designation;**

**[(I)](K) Upon completion of a review, the qualified**

contractors from the review team shall submit a report of their findings to the department. This report shall state whether the specific standards for stroke center designation have or have not been met and if not met, in what way they were not met. This report shall detail the hospital/stroke center's strengths, weaknesses, deficiencies, and recommendations for areas of improvement. This report shall also include findings from patient chart audits and a narrative summary of the following areas: prehospital, hospital, stroke service, emergency department, operating room, angiography suites, recovery room, clinical lab, intensive care unit, rehabilitation, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department shall have the final authority to determine compliance with the rules of this chapter;

**[(J)](L)** The department shall return a copy of the report to the chief executive officer, the stroke medical director, and the stroke program manager/coordinator of the hospital/stroke center reviewed. Included within the report shall be notification indicating whether the hospital/stroke center has met the criteria for stroke center designation or has failed to meet the criteria for the stroke center designation requested. Also, if a focus review of the stroke center is required, the time frame for this focus review will be shared with the chief executive officer, the stroke medical director, and the stroke program manager/coordinator of the stroke center reviewed;

**[(K)](M)** When the hospital/stroke center is found to have deficiencies, the hospital/stroke center shall submit a plan of correction to the department. The plan of correction shall include identified deficiencies, actions to be taken to correct deficiencies, time frame in which the deficiencies are expected to be resolved, and the person responsible for the actions to resolve the deficiencies. A plan of correction form shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings and designation. If a focus review is required, then the stroke center shall be allowed a minimum period of six (6) months to correct deficiencies;

**[(L)](N)** A stroke center shall make the department aware in writing within thirty (30) days if there are any changes in the stroke center's name, address, contact information, chief executive officer, stroke medical director, or stroke program manager/coordinator;

**(O) Failure of a hospital/stroke center to provide all medical records and quality improvement documentation necessary for the department to conduct a stroke review in order to determine if the requirements of 19 CSR 30-40.730 have been met shall result in the revocation of the hospital/stroke center's designation as a stroke center;**

**[(M)](P)** Any person aggrieved by an action of the Department of Health and Senior Services affecting the stroke center designation pursuant to Chapter 190, RSMo, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination thereon by the Administrative Hearing Commission under Chapter 621, RSMo. It shall not be a condition to such determination that the person aggrieved seek reconsideration, a rehearing, or exhaust any other procedure within the department; and

**[(N)](Q)** The department may deny, place on probation, suspend, or revoke such designation in any case in which it has **[reasonable cause to believe] determined** that there has been a substantial failure to comply with the provisions of Chapter 190, RSMo, or any rules or regulations promulgated pursuant to this chapter. If the Department of Health and Senior Services has **[reasonable cause to believe] determined** that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site

reviews of the hospital to verify compliance. If a stroke center fails two (2) consecutive on-site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245, RSMo, or rules adopted by the department pursuant to sections 190.001 to 190.245, RSMo, its center designation shall be revoked.

(3) Hospitals seeking stroke center designation by the department based on their current certification **or verification** as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall meet the following requirements:

(A) An application for stroke center designation by the department for hospitals that have been certified **or verified** as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to make a determination of eligibility for review and designation in accordance with the rules of this chapter. The application for stroke certified hospital designation form, included herein, is available at the Health Standards and Licensure (HSL) office, or online at the department's website at [www.health.mo.gov](http://www.health.mo.gov), or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for stroke center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation **[or expiration of the current designation]**;

**[(C)]** *Annually from the date of designation by the department, submit to the department proof of certification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program and the names and contact information of the medical director of the stroke center and the program manager of the stroke center;*

**[(D)](C)** Within thirty (30) days of any changes **or receipt of a certificate or verification, the hospital shall** submit~~[,]~~ to the department proof of certification or verification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program and the names and contact information of the medical director of the stroke center and the program manager of the stroke center. **A certificate or verification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall accompany the application for stroke certified hospital designation form. A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is certified or verified as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program for which the hospital used to receive its corresponding designation with the department as a stroke center, whether because the hospital voluntarily surrendered this certificate or verification, or because the hospital's certificate or verification was suspended or revoked by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program or expired;**

**[(E)]** *Submit to the department a copy of the certifying organization's final stroke certification survey results within thirty (30) days of receiving such results;*

**[(F)]** *Submit to the department a completed application for stroke certified hospital designation form every four (4) years;*

**[(G)]** *Participate in the emergency medical services regional system of stroke care in its respective emergency medical services region as defined in 19 CSR 30-40.302.;*

**[(H)](D)** Any hospital designated as a level III stroke center that is certified **or verified** by the Joint Commission, DNV-GL

Healthcare or Healthcare Facilities Accreditation Program as an acute stroke-ready center shall have a formal agreement with a level I or level II stroke center designated by the department for physician consultative services for evaluation of stroke patients for thrombolytic therapy and the care of the patient post-thrombolytic therapy;

*[(I)](E)* Participate in local and regional emergency medical services systems *[by reviewing and sharing outcome data and]* **for purposes of** providing training, *[and]* **sharing** clinical educational resources, **and collaborating on improving patient outcomes;**

*[(J)]* **Submit data to meet the data submission requirements outlined in 19 CSR 30-40.730(1)(Q);]**

*[(K)](F)* The designation of a hospital as a stroke center pursuant to section (3) shall continue if such hospital retains certification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program; and

*[(L)](G)* The department may remove a hospital's designation as a stroke center if requested by the hospital or the department determines that the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program certification **or verification** has been suspended or revoked. Any decision made by the department to withdraw the designation of a stroke center that is based on the revocation or suspension of a certification **or verification** by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall not be subject to judicial review.



Date \_\_\_\_\_

*AUTHORITY: sections 190.185 and 192.006, RSMo 2016, and section 190.241, RSMo Supp. [2017] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Aug. 7, 2017, effective Aug. 17, 2017, expired Feb. 22, 2018. Amended: Filed Aug. 7, 2017, effective March 30, 2018. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.*

*PRIVATE COST: This emergency amendment will cost private entities one thousand dollars (\$1,000) in the time the emergency is effective.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Department of Health and Senior Services  
Division Title: Division of Regulation and Licensure  
Chapter Title: 19 CSR 30-40.720 Stroke Center Designation Application and Review.**

<b>Rule Number and Title:</b>	<b>19 CSR 30-40.720 Stroke Center Designation Application and Review</b>
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Four (4) hospitals/stroke centers	\$1,000 in the time the emergency is effective
<b>TOTAL COSTS =</b>	<b>\$1,000 in the time the emergency is effective</b>

**III. WORKSHEET**

Four (4) private hospitals/stroke centers reviewed during the time that the emergency amendment is effective X \$250.00 = \$1,000 for the hospitals/stroke centers reviewed during the time that the emergency amendment is effective.

**IV. ASSUMPTIONS**

There are currently thirty-seven (37) Level I-IV stroke centers designated with the department. The department anticipates that four (4) private hospitals/stroke centers will be reviewed during the time the emergency amendment is in effect.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.720 will cost hospitals/stroke centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

**TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 30 – Division of Regulation and Licensure  
Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

**EMERGENCY AMENDMENT**

**19 CSR 30-40.730 Standards for Stroke Center Designation.**

The department is amending sections (1), (3), and (4) and renumbering through section (4).

*PURPOSE: This amendment changes continuing education hours to be consistent with required continuing education requirements by national designating or verifying bodies of stroke centers, removes continuing medical education requirements for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine and who are practicing in the emergency department of a stroke center, and adds an option for stroke centers to enter stroke data into an national data registry or databank that will allow the stroke center to perform its performance improvement and patient safety program requirements.*

*EMERGENCY STATEMENT: This emergency amendment makes several updates to this rule that were prompted by the passage of House Bill 2331 which passed during the 2022 legislative session. House Bill 2331 made changes to section 190.241, RSMo. House Bill 2331 prohibits the department from requiring physicians, nurses and other providers at stroke centers from being required to obtain continuing education on stroke for any more than what is required by national designating or verifying bodies of stroke centers. House Bill 2331 also prohibits the department from requiring physicians to obtain continuing education on stroke for those physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AEBEM) and who are practicing in the emergency department of a stroke center. Finally, House Bill 2331 allows the stroke centers to enter stroke data into a national data registry or national databank that still allows them to meet the performance improvement and patient safety program requirements for stroke centers. This emergency amendment is in the interest of both the hospitals and the department to make all parties aware of how many continuing education hours on stroke that hospital staff are required to have during stroke reviews based on the changes made to section 190.241, RSMo. This emergency amendment is also needed in order to allow stroke centers to enter stroke data into a national data registry or national data bank that they are already using and not have to transfer the data or manually enter data into the department's stroke registry in order to save staff time. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri and United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires June 4, 2023.*

(1) General Standards for Stroke Center Designation.

(F) The stroke center shall appoint a physician to serve as the stroke medical director. A stroke medical director shall be appointed at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. A level I stroke medical director shall have appropriate qualifications, experience, and training. A board-certified or board-admissible neurologist or other neuro-specialty trained physician is recommended. If the stroke medical director is board-certified or board-admissible, then one (1) of the following additional qualifications shall be met and documented. If the stroke medical director is not board-certified, then two (2) of the following additional qualifications shall be met and documented:

A. Completion of a stroke fellowship; (I-R)

B. Participation (as an attendee or faculty) in one (1) national or international stroke course or conference each year or two (2) regional or state stroke courses or conferences each year; or (I-R)

C. Five (5) or more peer-reviewed publications on stroke. (I-R)

2. A level II stroke medical director shall have appropriate qualifications, experience, and training. A board-certified or board-admissible physician with training and expertise in cerebrovascular disease is recommended. If the stroke medical director is board-certified or board-admissible, then one (1) of the following additional qualifications shall be met. If the stroke medical director is not board-certified, then two (2) of the following additional qualifications shall be met and documented:

A. Completion of a stroke fellowship; (II-R)

B. Participation (as an attendee or faculty) in one (1) national or international stroke course or conference each year or two (2) regional or state stroke courses or conferences each year; or (II-R)

C. Five (5) or more peer-reviewed publications on stroke. (II-R)

3. A level III and IV stroke medical director shall have the appropriate qualifications, experience, and training. A board-certified or board-admissible physician is recommended. If the stroke medical director is not board-certified or board-admissible, then the following additional qualifications shall be met and documented:

A. Complete a minimum of ~~ten (10)~~ **four (4)** hours of continuing medical education (CME) in the area of cerebrovascular disease every ~~other~~ year; and (III-R, IV-R)

B. Attend one (1) national, regional, or state meeting every three (3) years in cerebrovascular disease. Continuing medical education hours earned at these meetings can count toward the ~~ten (10)~~ **four (4)** required continuing medical education hours **for Level III stroke medical directors**. (III-R, IV-R)

4. The stroke medical director shall meet the department's continuing medical education requirements for stroke medical directors as set forth in section (4) of this rule. (I-R, II-R, III-R, IV-R)

5. The stroke center shall have a job description and organizational chart depicting the relationship between the stroke medical director and the stroke center services. (I-R, II-R, III-R, IV-R)

6. The stroke medical director is encouraged to be a member of the stroke call roster. (I-R, II-R, III-R, IV-R)

7. The stroke medical director shall be responsible for the oversight of the education and training of the medical and clinical staff in stroke care. This includes a review of the appropriateness of the education and training for the practitioner's level of responsibility. (I-R, II-R, III-R, IV-R)

8. The stroke medical director shall participate in the stroke center's research and publication projects. (I-R)

(Q) Stroke centers shall enter data into ~~the Missouri~~ a stroke registry as follows:

1. ~~All s~~Stroke centers shall submit data into the department's Missouri stroke registry on each stroke patient

who is admitted to the stroke center, transferred out of the stroke center, or dies as a result of the stroke (independent of hospital admission or hospital transfer status). The data required to be submitted into the Missouri stroke registry by the stroke centers is listed and explained in the document entitled "Time Critical Diagnosis Stroke Center Registry Data Elements" dated March 1, 2012, which is incorporated by reference in this rule and is available at the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570 or on the department's website at [www.health.mo.gov](http://www.health.mo.gov). This rule does not incorporate any subsequent amendments or additions; (I-R, II-R, III-R, IV-R)].

[2.] The data [required in paragraph (1)(Q)1. above] shall be submitted electronically into the Missouri stroke registry via the department's website at [www.health.mo.gov](http://www.health.mo.gov); or (I-R, II-R, III-R, IV-R)

**2. Stroke centers shall submit data into a national data registry or data bank capable of being used by the stroke center to perform its ongoing performance improvement and patient safety program requirements for its stroke patients. The stroke center shall submit data for each data element included in the national data registry or data bank's data system; (I-R, II-R, III-R, IV-R)**

3. The data required in paragraph (1)(Q)1 and 2 above shall be submitted electronically into the [Missouri] stroke registry on at least a quarterly basis for that calendar year. Stroke centers have ninety (90) days after the quarter ends to submit the data electronically into the [Missouri] stroke registry; (I-R, II-R, III-R, IV-R)

4. The data submitted by the stroke centers shall be complete and current; and (I-R, II-R, III-R, IV-R)

5. The data shall be managed in compliance with the confidentiality requirements and procedures contained in section 192.067, RSMo. (I-R, II-R, III-R, IV-R)

(3) Standards for Hospital Resources and Capabilities for Stroke Center Designation.

(A) The stroke center shall meet emergency department standards listed below. (I-R, II-R, III-R, IV-R)

1. The emergency department staffing shall meet the following requirements:

A. The emergency department in the stroke center shall provide immediate and appropriate care for the stroke patient; (I-R, II-R, III-R, IV-R)

B. A level I stroke center shall have a medical director of the emergency department who shall be board-certified or board-admissible in emergency medicine by the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada; (I-R)

C. A level II stroke center shall have a medical director of the emergency department who shall be a board-certified or board-admissible physician; (II-R)

D. A level III and IV stroke center shall have a medical director of the emergency department who is recommended to be a board-certified or board-admissible physician; (III-R, IV-R)

E. There shall be an emergency department physician credentialed for stroke care by the stroke center covering the emergency department twenty-four (24) hours a day, seven (7) days a week; (I-R/II-R, II-R/II-R, III-R/II-R, IV-R/II-R)

F. The emergency department physician who provides coverage shall be current in continuing medical education in the area of cerebrovascular disease; (I-R, [II-R, III-R, IV-R])

G. There shall be a written policy defining the relationship of the emergency department physicians to other physician members of the stroke team; (I-R, II-R, III-R, IV-R)

H. Registered nurses in the emergency department

shall be current in continuing education requirements as set forth in section (4) of this rule; (I-R, [II-R, III-R, IV-R])

I. All registered nurses assigned to the emergency department shall be determined to be credentialed in the care of the stroke patient by the stroke center within one (1) year of assignment and remain current in continuing education requirements as set forth in section (4) of this rule; and (I-R, II-R, III-R, IV-R)

J. The emergency department in stroke centers shall have written care protocols for identification, triage, and treatment of acute stroke patients that are available to emergency department personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R, IV-R)

2. Nursing documentation for the stroke patient shall be on a stroke flow sheet approved by the stroke medical director and the stroke program coordinator/manager. (I-R, II-R, III-R, IV-R)

3. The emergency department shall have at least the following equipment for resuscitation and life support available to the unit:

A. Airway control and ventilation equipment including:

(I) Laryngoscopes; (I-R, II-R, III-R, IV-R)

(II) Endotracheal tubes; (I-R, II-R, III-R, IV-R)

(III) Bag-mask resuscitator; (I-R, II-R, III-R, IV-R)

(IV) Sources of oxygen; and (I-R, II-R, III-R, IV-R)

(V) Mechanical ventilator; (I-R, II-R, III-R)

B. Suction devices; (I-R, II-R, III-R, IV-R)

C. Electrocardiograph (ECG), cardiac monitor, and defibrillator; (I-R, II-R, III-R, IV-R)

D. Central line insertion equipment; (I-R, II-R, III-R)

E. All standard intravenous fluids and administration devices including intravenous catheters and intraosseous devices; (I-R, II-R, III-R, IV-R)

F. Drugs and supplies necessary for emergency care; (I-R, II-R, III-R, IV-R)

G. Two- (2-) way communication link with emergency medical service (EMS) vehicles; (I-R, II-R, III-R, IV-R)

H. End-tidal carbon dioxide monitor; and (I-R, II-R, III-R, IV-R)

I. Temperature control devices for patient and resuscitation fluids. (I-R, II-R, III-R IV-R)

4. The stroke center emergency department shall maintain equipment following the hospital's preventive maintenance schedule and document when this equipment is checked. (I-R, II-R, III-R, IV-R)

(4) Continuing Medical Education (CME) and Continuing Education Standards for Stroke Center Designation.

(A) The stroke center shall ensure that staff providing services to stroke patients receives required continuing medical education and continuing education and document this continuing medical education and continuing education for each staff member. The department shall allow up to one (1) year from the date of the hospital's initial stroke center designation for stroke center staff members to complete all of the required continuing medical education and continuing education if the stroke center staff complete and document that at least half of the required continuing medical education and/or continuing education hours have been completed for each stroke center staff member at the time of on-site initial application review. The stroke center shall submit documentation to the department within one (1) year of the initial designation date that all continuing medical education and continuing education requirements for stroke center staff members have been met in order to maintain the stroke center's designation. (I-R, II-R, III-R, [IV-R])

(B) The stroke call roster members shall complete the following continuing education requirements:

1. Level I core team members of the stroke call roster shall complete a minimum of *[ten (10)] eight (8)* hours of continuing education in cerebrovascular disease every year, and it is recommended that a portion of those hours shall be on stroke care. All other members of the stroke call roster in level I stroke centers shall complete a minimum average of *[ten (10)] eight (8)* hours of continuing education in cerebrovascular disease every year, **except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department.** This continuing education shall be reviewed for appropriateness to the practitioner's level of responsibility by the stroke medical director; **and (I-R)**

2. Level II core team members of the stroke call roster shall complete a minimum of eight (8) hours of continuing education in cerebrovascular disease every year, and it is recommended that a portion of those hours be in stroke care. *[All other members of the stroke call roster in level II stroke centers shall complete a minimum average of eight (8) hours of continuing education in cerebrovascular disease every year. This continuing education shall be reviewed for appropriateness to the practitioner's level of responsibility by the stroke medical director; and] (II-R)*

3. Level III and IV stroke call roster members shall complete a minimum average of eight (8) hours of continuing education in cerebrovascular disease every two (2) years. This continuing education shall be reviewed for appropriateness to the practitioner's level of responsibility by the stroke medical director. *(III-R, IV-R)]*

(C) The stroke medical director shall complete the following continuing medical education requirements:

1. Level I **and Level II** stroke medical directors shall complete a minimum of *[twelve (12)] eight (8)* hours of continuing medical education every year in the area of cerebrovascular disease; **and (I-R, II-R)**

2. Level III stroke medical directors shall complete a minimum of *[eight (8)] four (4)* hours of continuing medical education every year in the area of cerebrovascular disease; **and]. (III-R)**

*[3. Level III and IV stroke medical directors shall complete a minimum of eight (8) hours of continuing medical education every two (2) years in the area of cerebrovascular disease. (III-R, IV-R)]*

(D) The stroke center's stroke program manager/coordinator shall complete the following continuing education requirements:

1. Level I program managers/coordinators shall:

A. Complete a minimum of *[ten (10)] eight (8)* hours of continuing education every year in cerebrovascular disease. This continuing education shall be reviewed by the stroke medical director for appropriateness to the stroke program manager/coordinator's level of responsibility; **and (I-R)**

B. Attend one (1) national, regional, or state meeting every two (2) years focused on the area of cerebrovascular disease. If the national or regional meeting provides continuing education, then that continuing education may count toward the annual requirement; **(I-R)**

2. Level II program managers/coordinators shall –

A. Complete a minimum average of eight (8) hours of continuing education every year in cerebrovascular disease. This continuing education shall be reviewed for appropriateness by the stroke medical director to the stroke program manager/coordinator's level of responsibility; **and (II-R)**

B. Attend one (1) national, regional, or state meeting every three (3) years focused on the area of cerebrovascular

disease. If the national, regional, or state meeting provides continuing education, then that continuing education may count toward the annual requirement; **and (II-R)**

3. Level III *[and IV]* center program managers/coordinators shall complete a minimum average of *[eight (8)] four (4)* hours of continuing education in cerebrovascular disease every *[two (2)] year[s]*. This continuing education shall be reviewed by the stroke medical director for appropriateness to the stroke program manager/coordinator's level of responsibility. **(III-R[, IV-R])**

(E) Emergency department personnel in stroke centers shall complete the following continuing education requirements:

1. Emergency department physicians in stroke centers shall complete –

A. Level I *[and II]* emergency department physicians providing stroke coverage shall complete a minimum *[average] of [four (4)] two (2)* hours of continuing medical education in cerebrovascular disease every year; **or], except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department. (I-R[, II-R])**

*[B. Level III and IV emergency department physicians providing stroke coverage shall complete a minimum average of six (6) hours of continuing medical education in cerebrovascular disease every two (2) years; and (III-R, IV-R)]*

2. Registered nurses assigned to the emergency departments in stroke centers shall complete –

A. Level I *[and II]* registered nurses shall complete a minimum of *[four (4)] two (2)* hours of cerebrovascular disease continuing education every year; **and (I-R[, II-R])**

*[B. Level III and IV registered nurses shall complete a minimum of six (6) hours of cerebrovascular disease continuing education every two (2) years; and (III-R, IV-R)]*

*[C.]B.* Registered nurses shall maintain core competencies in the care of the stroke patient annually as determined by the stroke center. Training to maintain these competencies may count toward continuing education requirements. **(I-R, II-R, III-R, IV-R)**

(F) Registered nurses assigned to the intensive care unit in the stroke centers who care for stroke patients shall complete the following continuing education requirements:

1. Level I intensive care unit registered nurses shall complete a minimum of *[ten (10)] eight (8)* hours of cerebrovascular related continuing education every year; **and (I-R)**

*[2. Level II intensive care unit registered nurses shall complete a minimum of eight (8) hours of cerebrovascular related continuing education every year; and (II-R)]*

*[3.]2.* The stroke medical director shall review the continuing education for appropriateness to the practitioner's level of responsibility. **(I-R[, II-R])**

(G) Stroke unit registered nurses in the stroke centers shall complete the following continuing education requirements:

1. All level I stroke unit registered nurses shall complete a minimum of *[ten (10)] eight (8)* hours of cerebrovascular disease continuing education every year; **and (I-R)**

*[2. All level II stroke unit registered nurses shall complete a minimum of eight (8) hours of cerebrovascular disease continuing education every year; (II-R)]*

*3. All level III stroke centers caring for stroke patients under an established plan for admitting and caring for stroke patients under a supervised relationship with a physician affiliated with a level I or II stroke center shall require registered nurses in the stroke unit complete a minimum of eight (8) hours of cerebrovascular disease continuing education every two (2) years; and (III-R)]*

[4.]2. The stroke medical director shall review the continuing education for appropriateness to the practitioner's level of responsibility. (I-R[, II-R, III-R])

*AUTHORITY:* sections 192.006 **and 190.185**, RSMo [2000] 2016, and section[s 190.185 and] 190.241, RSMo Supp. [2012] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

*PUBLIC COST:* This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.

*PRIVATE COST:* This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.

## TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES

### Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations

#### EMERGENCY AMENDMENT

**19 CSR 30-40.740 Definitions and Abbreviations Relating to ST-Segment Elevation Myocardial Infarction (STEMI) Centers.** The department is amending section (1).

*PURPOSE:* This amendment adds virtual reviews to the definitions for STEMI centers.

*EMERGENCY STATEMENT:* This emergency amendment adds virtual reviews to the definitions for STEMI centers. This amendment was prompted by the passage of House Bill 2331 that passed during the 2022 legislative session. House Bill 2331 made changes to section 190.241, RSMo and allows the department to conduct virtual reviews rather than only on-site reviews of STEMI centers. This emergency amendment is necessary in order to make this rule consistent with the changes made in House Bill 2331 that became effective on August 28, 2022. This emergency amendment is in the interest of both the hospitals and the department. The emergency amendment is necessary for the department to conduct virtual reviews instead of only on-site reviews. Due to complications caused by COVID-19, the department is having a difficult time getting qualified contractors to review the STEMI centers and hospitals are still being challenged with COVID-19 in their hospitals. National certifying bodies began using virtual reviews during the COVID-19 pandemic and these virtual reviews have proven to be a solution to conducting reviews while COVID-19 is still an issue for out-of-state-qualified contractors traveling to these reviews and for hospitals having to handle a review team in their hospitals. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires on June 4, 2023.

(1) For the purposes of 19 CSR 30-40.750 and 19 CSR 30-40.760

the following terms shall mean:

(KKK) **Virtual review- a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.**

*AUTHORITY:* sections 192.006 **and 190.185**, RSMo [2000] 2016, and section[s 190.185 and] 190.241, RSMo Supp. [2012] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

*PUBLIC COST:* This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.

*PRIVATE COST:* This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.

## TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES

### Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations

#### EMERGENCY AMENDMENT

**19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review.** The department is amending sections (2) and (3), and amending the application for STEMI center designation form.

*PURPOSE:* This amendment adds virtual review requirements, clarifies honorarium and payment requirements for virtual reviews, updates language to be consistent with HB 2331 amendment, adds a requirement that hospitals must provide the department with required medical records and quality improvement documentation or be revoked, changes the requirements for hospitals participating in local and regional emergency medical services system, removes the data submission requirement for hospitals verified or certified by department approved national certifying bodies, and updates what the hospitals have to submit to the department to confirm verification or certification with national certifying bodies and when to submit changes of this verification or certification. This amendment also makes changes to the application for STEMI center designation form included herein in section (3)(A) by changing the certification section to reflect the new requirements for notification of changes and participation in local and regional emergency medical services systems and removing the data submission requirement.

*EMERGENCY STATEMENT:* This emergency amendment makes several updates to this rule that were prompted by the passage of House Bill 2331 that passed during the 2022 legislative session. House Bill 2331 made changes to sections 190.241 and 190.245, RSMo which became effective on August 28, 2022. House Bill 2331 allows the department to conduct virtual reviews rather than only on-site reviews of these STEMI centers. House Bill 2331 added a requirement for hospitals to provide the department with quality improvement documentation necessary for the department to conduct a STEMI review or the hospital's STEMI center designation will be revoked. Finally, House Bill 2331 made changes about how hospitals which are verified or certified by national certifying bodies designated by the department need

*to report changes of their verification or certification to the department and how these hospitals participate in local and regional emergency medical services systems. This emergency amendment is necessary in order to make this rule consistent with the changes made in House Bill 2331 that became effective on August 28, 2022. This emergency amendment is in the interest of both the hospitals and the department to ensure that hospitals which are applying for designation with the department because they are certified or verified by a department approved national designating body do not have to provide the department with any additional information than what is now required by the changes made to section 190.241, RSMo by HB 2331. Finally, the emergency amendment is necessary for the department to conduct virtual reviews instead of only on-site reviews. Due to complications caused by COVID-19, the department is having a difficult time in getting qualified contractors to review the STEMI centers and hospitals are still being challenged with COVID-19 in their hospitals. National certifying bodies began using virtual reviews during the COVID-19 pandemic and these virtual reviews have proven to be a solution to conducting reviews while COVID-19 is still an issue for out-of-state- qualified contractors traveling to these reviews and for hospitals having to handle a review team in their hospitals. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri and United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires on June 4, 2023.*

(2) Hospitals requesting to be reviewed and designated as a STEMI center by the department shall meet the following requirements:

(D) **The department may conduct an onsite review, a virtual review or a combination thereof on the hospitals/STEMI centers. For announced reviews that are scheduled with the hospitals/STEMI centers, the department will make the hospitals/STEMI centers aware at least thirty (30) days prior to the scheduled review whether the department intends that the review will be conducted onsite and/or virtually. Due to unforeseen circumstances, the department may need to change whether the review is conducted onsite and/or virtually less than thirty (30) days before the announced review. The department will contact the hospitals/STEMI centers to make the hospitals/STEMI centers aware of any changes about how the review will be conducted, either onsite and/or virtually, prior to the date of the announced review. The different types of [site] reviews to be conducted on hospitals/STEMI centers seeking STEMI center designation by the department include:**

1. An initial review shall occur on a hospital applying to be initially designated as a STEMI center. An initial review shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **This review may occur onsite and/or virtually;**

2. A validation review shall occur on a designated STEMI center applying for renewal of its designation as a STEMI center. Validation reviews shall occur no less than every three (3) years. A validation review shall include interviews with designated STEMI center staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **This review may occur onsite**

**and/or virtually;** and

3. A focus review shall occur on a designated STEMI center in which an initial or validation review was conducted and substantial deficiency(ies) were cited. A review of the physical plant will not be necessary unless a deficiency(ies) was cited in the physical plant in the preceding validation review. The focus review team shall be comprised of a representative from the department and may include a qualified contractor(s) with the required expertise to evaluate corrections in areas where deficiencies were cited. **This review may occur onsite and/or virtually;**

(E) STEMI center designation shall be valid for a period of three (3) years from the date the STEMI center/hospital is designated.

1. STEMI center designation shall be site specific and non-transferable when a STEMI center changes location.

2. Once designated as a STEMI center, a STEMI center may voluntarily surrender the designation at any time without giving cause, by contacting the department in writing. In these cases, the application and review process shall be completed again before the designation may be reinstated;

(H) Hospitals/STEMI centers shall be responsible for paying expenses related to the costs of the qualified contractors to review their respective hospitals/STEMI center during initial, validation, and focus reviews. The department shall be responsible for paying the expenses of its representative. Costs of the review to be paid by the hospital/STEMI center include:

1. An honorarium shall be paid to each qualified contractor of the review team **whether the review occurs on-site or virtually**. Qualified contractors of the review team for level I and II STEMI center reviews shall be paid *[six hundred dollars (\$600) for the day of travel per reviewer and eight hundred fifty dollars (\$850) for the day of the review] one thousand four hundred fifty dollars (\$1,450)* per reviewer. Qualified contractors of the review team for level III and IV STEMI center reviews shall be paid *[five hundred dollars (\$500) for the day of travel per reviewer and five hundred dollars (\$500) for the day of the review] one thousand dollars (\$1,000)* per reviewer. This honorarium shall be paid to each qualified contractor of the review team at the time the site survey begins **if on-site or prior to the review begins if the review is conducted virtually;**

2. Airfare shall be paid for each qualified contractor of the review team, if applicable;

3. Lodging shall be paid for each qualified contractor of the review team, **unless the review is conducted virtually**. The hospital/STEMI center shall secure the appropriate number of hotel rooms for the qualified contractors and pay the hotel directly; and

4. Incidental expenses, if applicable, for each qualified contractor of the review team shall not exceed two hundred fifty dollars (\$250) and may include the following:

A. Airport parking;

B. Checking bag charges;

C. Meals during the review; and

D. Mileage to and from the review if no airfare was charged by the reviewer. **If the reviewer solely participated virtually in the review and did not travel by vehicle to the review, then no mileage shall be paid.** Mileage shall be paid at the federal mileage rate for business miles as set by the Internal Revenue Service (IRS). Federal mileage rates can be found at the website [www.irs.gov](http://www.irs.gov);

(I) Hospitals/STEMI centers being reviewed by the department through a virtual survey shall do the following:

1. **Provide a videoconferencing platform to be used for the hospital/STEMI center virtual review;**

2. **Provide a live tour of the hospital;**

3. **Ensure the videoconferencing platform used during the review is compliant with state and federal laws for**

protected health information;

4. Assign an onsite visit coordinator for the review. The onsite visit coordinator role cannot be fulfilled by the STEMI program manager. This onsite visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:

A. Scheduling the videoconferencing meetings;

B. Sending out calendar invitations;

C. Providing Electronic Medical Record (EMR) access to designated individuals;

D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and

E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors and the department;

5. Assign one staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the STEMI program manager, the STEMI program medical director, the STEMI program registrar or the onsite visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR;

6. Provide the department with requested patient care report information for the review no later than thirty (30) days prior to the virtual review;

7. Provide the department with requested medical records, PIPS documentation, registry report and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;

8. Schedule a prereview call with the qualified contractors, the department, the STEMI program medical director, the STEMI program manager, the staff navigators and the onsite visit coordinator approximately one (1) week prior to the virtual review;

9. Test the functionality of the videoconferencing platform for the live tour of the hospital prior to the prereview call; and

10. Provide a list of attendees for the review meeting and their roles to the review team and the department prior to the virtual review;

(J) The department may conduct an on-site review of the hospital prior to the virtual review to ensure that the hospital meets the requirements for STEMI center designation;

[(I)](K) Upon completion of a review, the qualified contractors from the review team shall submit a report of their findings to the department. This report shall state whether the specific standards for STEMI center designation have or have not been met and if not met, in what way they were not met. This report shall detail the hospital/STEMI center's strengths, weaknesses, deficiencies, and recommendations for areas of improvement. This report shall also include findings from patient chart audits and a narrative summary of the following areas: prehospital, hospital, STEMI service, emergency department, operating room, angiography suites, recovery room, clinical lab, intensive care unit, rehabilitation, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department shall have the final authority to determine compliance with the rules of this chapter;

[(J)](L) The department shall return a copy of the report to the chief executive officer, the STEMI medical director, and the STEMI program manager/coordinator of the hospital/STEMI center reviewed. Included within the report shall be

notification indicating whether the hospital/STEMI center has met the criteria for STEMI center designation or has failed to meet the criteria for STEMI center designation as requested. Also, if a focus review of the STEMI center is required, the time frame for this focus review will be shared with the chief executive officer, the STEMI medical director, and the STEMI program manager/coordinator of the STEMI center reviewed;

[(K)](M) When the hospital/STEMI center is found to have deficiencies, the hospital/STEMI center shall submit a plan of correction to the department. The plan of correction shall include identified deficiencies, actions to be taken to correct deficiencies, time frame in which the deficiencies are expected to be resolved, and the person responsible for the actions to resolve the deficiencies. A plan of correction form shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings and designation. If a focus review is required, the STEMI center shall be allowed a minimum period of six (6) months to correct deficiencies;

[(L)](N) No hospital shall hold itself out as a STEMI center designated by the department until given written approval by the department. The department shall give written approval to the hospitals to begin holding themselves out as designated STEMI centers by the department after all initial STEMI reviews have been completed for those hospitals which applied for STEMI review and designation with the department during the first round of applications and the time for plans of corrections have expired;

[(M)](O) A STEMI center shall make the department aware in writing within thirty (30) days if there are any changes in the STEMI center's name, address, contact information, chief executive officer, STEMI medical director, or STEMI program manager/coordinator;

(P) Failure of a hospital/STEMI center to provide all medical records and quality improvement documentation necessary for the department to conduct a STEMI review in order to determine if the requirements of 19 CSR 30-40.760 have been met shall result in the revocation of the hospital/STEMI center's designation as a STEMI center;

[(N)](Q) Any person aggrieved by an action of the department affecting the STEMI center designation pursuant to Chapter 190, RSMo, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination by the Administrative Hearing Commission under Chapter 621, RSMo. It shall not be a condition to such determination that the person aggrieved seek reconsideration, a rehearing, or exhaust any other procedure within the department; and

[(O)](R) The department may deny, place on probation, suspend, or revoke such designation in any case in which it has *[reasonable cause to believe]* determined that there has been a substantial failure to comply with the provisions of Chapter 190, RSMo, or any rules or regulations promulgated pursuant to this chapter. If the department has *[reasonable cause to believe]* determined that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site reviews of the hospital to verify compliance. If a STEMI center fails two (2) consecutive on-site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245, RSMo, or rules adopted by the department pursuant to sections 190.001 to 190.245, RSMo, its center designation shall be revoked.

(3) Hospitals seeking STEMI center designation by the department based on their current certification or verification as a STEMI center by the Joint Commission, American Heart Association, or American College of Cardiology shall meet the following requirements:

(A) An application for STEMI center designation by the department for hospitals that have been certified **or verified** as a STEMI/chest pain center by the Joint Commission, American Heart Association, or American College of Cardiology shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to make a determination of eligibility for review and designation in accordance with the rules of this chapter. The application for STEMI certified hospital designation form, included herein, is available at the Health Standards and Licensure (HSL) office, or online at the department's website at [www.health.mo.gov](http://www.health.mo.gov), or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for STEMI center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation or expiration of the current designation;

(C) No hospital shall hold itself out as a STEMI center designated by the department until given written approval by the department. The department shall give written approval to the hospitals to begin holding themselves out as designated STEMI centers by the department after all initial STEMI reviews have been completed for those hospitals which applied for STEMI review and designation with the department during the first round of applications and the time for plans of corrections have expired. This does not prohibit the hospitals from holding themselves out as certified STEMI/chest pain centers by the Joint Commission, the American Heart Association, or the American College of Cardiology;

*[(D) Annually from the date of designation by the department submit to the department proof of certification as a STEMI/chest pain center by the Joint Commission, the American Heart Association, or the American College of Cardiology and the names and contact information of the medical director of the STEMI/chest pain center and the program manager of the STEMI chest pain center;]*

*[(E)] Within thirty (30) days of any changes **or receipt of a certificate or verification**, the hospital shall submit to the department proof of certification as a STEMI/chest pain center by the Joint Commission, the American Heart Association, or the American College of Cardiology and the names and contact information of the medical director of the STEMI/chest pain center and the program manager of the STEMI/chest pain center. **A certificate or verification as a STEMI center by the Joint Commission, the American Heart Association, or the American College of Cardiology shall accompany the application for STEMI certified hospital designation form.** A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is certified or verified as a STEMI center by the Joint Commission, the American Heart Association or the American College of Cardiology for which the hospital used to receive its corresponding designation by the department as a STEMI center, whether because the hospital voluntarily surrendered this certificate or verification, or because the hospital's certificate or verification was suspended or revoked by the Joint Commission, the American Heart Association or the American College of Cardiology or expired;*

*[(F) Submit to the department a copy of the certifying organization's final STEMI/chest pain center certification survey results within thirty (30) days of receiving such results;*

*(G) Submit to the department a completed application for STEMI certified hospital designation form every three (3) years;*

*(H) Participate in the emergency medical services regional system of STEMI care in its respective emergency medical services region as defined in 19 CSR 30-40.302;*

*(I) Any hospital designated as a level III STEMI center that is certified by the Joint Commission, the American Heart Association, or the American College of Cardiology shall have a formal agreement with a level I or level II STEMI center designated by the department for physician consultative services for evaluation of STEMI patients;]*

*[(J)](E) Participate in local and regional emergency medical services systems **[by reviewing and sharing outcome data and] for purposes of** providing training **[and]**, sharing clinical educational resources, and collaborating on improving patient outcomes;*

*[(K) Submit data to meet the data submission requirements in section 190.241, RSMo, and 19 CSR 30-40.760;]*

*[(L)](F) The designation of a hospital as a STEMI center pursuant to section (3) shall continue if such hospital retains certification as a STEMI center by the Joint Commission, the American Heart Association, or the American College of Cardiology; and*

*[(M)](G) The department may remove a hospital's designation as a STEMI center if requested by the hospital or the department determines that the Joint Commission, the American Heart Association, or American College of Cardiology certification **or verification** has been suspended or revoked. The department may also remove a hospital's designation as a STEMI center if the department determines the hospital's certification **or verification** with the Joint Commission, the American Heart Association, or American College of Cardiology has expired. Any decision made by the department to withdraw the designation of a STEMI center that is based on the revocation or suspension of a certification **or verification** by the Joint Commission, the American Heart Association, or the American College of Cardiology shall not be subject to judicial review.*



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION OF HEALTH STANDARDS AND LICENSURE  
**APPLICATION FOR ST-ELEVATION MYOCARDIAL INFARCTION (STEMI)  
CERTIFIED HOSPITAL DESIGNATION**

<b>SECTION A</b>			
In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a STEMI center. Please complete all information.			Organization's STEMI Identification Number
<b>Current STEMI Certification Organization and Level</b>			
<b>LEVEL I</b> <input type="checkbox"/> Joint Commission, Comprehensive Cardiac Center	<b>LEVEL II</b> <input type="checkbox"/> American Heart Association, Mission Lifeline Percutaneous Coronary Intervention (PCI)/ STEMI Receiving Center  <input type="checkbox"/> American College of Cardiology, Chest Pain with PCI Center  <input type="checkbox"/> American College of Cardiology, Chest Pain with PCI and Resuscitation Center  <input type="checkbox"/> Joint Commission, Primary Heart Attack Center	<b>LEVEL III</b> <input type="checkbox"/> American Heart Association, Mission Lifeline Non/PCI STEMI Referral Center  <input type="checkbox"/> Joint Commission, Chest Pain Center  <input type="checkbox"/> Joint Commission, Primary Acute Myocardial Infarction (AMI) Center  <input type="checkbox"/> American College of Cardiology, Chest Pain Center  <input type="checkbox"/> Joint Commission, Acute Heart Attack Ready Center	
<b>HOSPITAL INFORMATION</b>			
Name of Hospital (Name to Appear on Designation Certificate )			Telephone Number
Address (Street and Number)	City	Zip Code	
<b>PROFESSIONAL INFORMATION</b>			
Chief Executive Officer		Chairman/President of Board of Trustees	
STEMI Medical Director (Name, email, and contact phone number)		STEMI Program Manager (Name, email, and contact phone number)	
<b>Section B</b>			
<b>The following should be submitted to the department as indicated:</b>			
<input type="checkbox"/> Proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology with the expiration date of the certification.			
<b>CERTIFICATION</b>			
We, the undersigned, hereby certify that: A. Within thirty (30) days of any changes or receipt of a certificate or verification, we will submit to the department proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology. B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of the STEMI center. C. Within thirty (30) days that our hospital is no longer certified or verified with the Joint Commission, the American Heart Association or the American College of Cardiology, whether because we voluntarily surrendered our certification or verification or because our certification or verification has been suspended or revoked by the Joint Commission, the American Heart Association or American College of Cardiology or expired, we will report this change in writing to the department. D. We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes. E. We understand that our designation as a STEMI center by the department shall continue only if our hospital remains certified as a STEMI center by the Joint Commission, the American Heart Association or the American College of Cardiology.			
Date of application _____			
Signed _____ Chairman/President of Board of Trustees, Owner, or one Partner of Partnership		Signed _____ Hospital Chief Executive Officer	
Signed _____ STEMI Medical Director		Signed _____ Director of Emergency Medicine	

*AUTHORITY: sections 190.185 and 192.006, RSMo 2016, and section 190.241, RSMo Supp. [2019] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Feb. 2, 2018, effective Feb. 12, 2018, expired Aug. 10, 2018. Amended: Filed Feb. 2, 2018, effective Aug. 30, 2018. Emergency amendment filed Aug. 28, 2019, effective Sept. 12, 2019, expired March 9, 2020. Amended: Filed Aug. 28, 2019, effective March 30, 2020. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.*

*PRIVATE COST: This emergency amendment will cost private entities one thousand dollars (\$1,000) in the time the emergency is effective.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Department of Health and Senior Services  
Division Title: Division of Regulation and Licensure  
Chapter Title: 19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI)  
Center Designation Application and Review.**

<b>Rule Number and Title:</b>	19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review
<b>Type of Rulemaking:</b>	Emergency Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Four (4) hospitals/STEMI centers	\$1,000 in the time the emergency is effective
<b>TOTAL COSTS =</b>	<b>\$1,000 in the time the emergency is effective</b>

**III. WORKSHEET**

Four (4) private hospitals/STEMI centers reviewed during the time that the emergency amendment is effective X \$250.00 = \$1,000 for the hospitals/STEMI centers reviewed during the time that the emergency amendment is effective.

**IV. ASSUMPTIONS**

There are currently forty-five (45) Level I-IV STEMI centers designated with the department. The department anticipates that four (4) private hospitals/STEMI centers will be reviewed during the time the emergency amendment is in effect.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.750 will cost hospitals/STEMI centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

**TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 30 – Division of Regulation and Licensure  
Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

**EMERGENCY AMENDMENT**

**19 CSR 30-40.760 Standards for ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation.** The department is amending sections (1), (3), and (4) and renumbering throughout section (4).

*PURPOSE: This amendment changes continuing education hours to be consistent with required continuing education requirements by national designating or verifying bodies of STEMI centers, removes continuing medical education requirements for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine and who are practicing in the emergency department of a STEMI center, and adds an option for STEMI centers to enter STEMI data into an national data registry or databank that will allow the STEMI center to perform its performance improvement and patient safety program requirements.*

*EMERGENCY STATEMENT: This emergency amendment makes several updates to this rule that were prompted by the passage of House Bill 2331 which passed during the 2022 legislative session. House Bill 2331 made changes to section 190.241, RSMo. House Bill 2331 prohibits the department from requiring physicians, nurses and other providers at STEMI centers from being required to obtain continuing education for any more than what is required by national designating or verifying bodies of STEMI centers. House Bill 2331 also prohibits the department from requiring physicians to obtain continuing education on STEMI for those physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department of a STEMI center. Finally, House Bill 2331 allows the STEMI centers to enter STEMI data into a national data registry or national databank that still allows them to meet the performance improvement and patient safety program requirements for STEMI centers. This emergency amendment is in the interest of both the hospitals and the department to make all parties aware of how many continuing education hours hospital staff are required to have during STEMI reviews based on the changes made to section 190.241, RSMo. This emergency amendment is also needed in order to allow STEMI centers to enter STEMI data into a national data registry or national data bank that they are already using and not have to transfer the data or manually enter data into the department's STEMI registry in order to save staff time. As a result, the department finds a compelling governmental interest, which requires this emergency action. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri and United States Constitutions**. The department believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 21, 2022, becomes effective December 7, 2022, and expires on June 4, 2023.*

(1) General Standards for STEMI Center Designation.

(G) The STEMI center shall appoint a physician to serve as the STEMI medical director with appropriate qualifications,

experience, and training. A STEMI medical director shall be appointed at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. Level I and II STEMI center medical directors shall be cardiologists or interventional cardiologists. It is recommended that the cardiologist or interventional cardiologist be board-certified or board-admissible in interventional cardiology or cardiology. (I-R, II-R)

2. Level III and IV STEMI center medical directors shall be physicians. A board-certified or board-admissible physician is recommended. (III-R, IV-R)

3. The STEMI center shall have a job description and organization chart depicting the relationship between the STEMI medical director and other services. (I-R, II-R, III-R, IV-R)

4. Level I and II STEMI medical directors are recommended to be members of the catheterization lab team call roster. (I-R, II-R)

5. The STEMI medical director shall meet the continuing medical education (CME) requirements as described in section (4) of this rule. (I-R, ~~II-R, III-R, IV-R~~)

6. The STEMI medical director shall be responsible for oversight of the education and training of the medical and clinical staff in STEMI care. This includes a review of the appropriateness of the education and training for the practitioner's level of responsibility. (I-R, II-R, III-R, IV-R)

7. Level I STEMI medical directors shall participate in the STEMI center's research and publication projects. (I-R)

(H) The STEMI center shall have a STEMI program coordinator/manager who is a registered nurse, other clinical staff, or qualified individual. The STEMI center shall have a STEMI program coordinator/manager at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. The STEMI center shall have a job description and organization chart depicting the relationship between the STEMI program coordinator/manager and other services. (I-R, II-R, III-R, IV-R)

2. The STEMI coordinator/manager shall meet continuing education requirements as described in section (4) of this rule. (I-R, ~~II-R, III-R, IV-R~~)

3. The STEMI program coordinator/manager shall participate in the formal STEMI center performance improvement and patient safety program. (I-R, II-R, III-R, IV-R)

(T) STEMI centers shall enter data into ~~[the Missouri]~~ a STEMI registry **as follows:**

1. ~~[All]~~ STEMI centers shall submit data into the department's Missouri STEMI registry on each STEMI patient who is admitted to the STEMI center, transferred out of the STEMI center, or dies as a result of the STEMI (independent of hospital admission or hospital transfer status). The data required to be submitted into the Missouri STEMI registry by the STEMI centers is listed and explained in the document entitled "Time Critical Diagnosis ST-Segment Elevation Myocardial Infarction (STEMI) Center Registry Data Elements" dated March 1, 2012, which is incorporated by reference in this rule and is available at the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570 or on the department's website at [www.health.mo.gov](http://www.health.mo.gov). This rule does not incorporate any subsequent amendments or additions; (~~I-R, II-R, III-R, IV-R~~).

~~[2.]~~ The data ~~[required in paragraph (1)(T)1. above]~~ shall be submitted electronically into the Missouri STEMI registry via the department's website at [www.health.mo.gov](http://www.health.mo.gov); or (I-R, II-R, III-R, IV-R)

**2. STEMI centers shall submit data into a national data registry or data bank capable of being used by the STEMI center to perform its ongoing performance improvement and patient safety program requirements for its STEMI patients. STEMI centers shall submit data for each data element included in the national data registry or data**

**bank's data system; (I-R, II-R, III-R, IV-R)**

3. This data required in paragraph (1)(T)1. and 2. above shall be submitted electronically into the [Missouri] STEMI registry on at least a quarterly basis for that calendar year. STEMI centers have ninety (90) days after the quarter ends to submit the data electronically into the [Missouri] STEMI registry; (I-R, II-R, III-R, IV-R)

4. The data submitted by the STEMI centers shall be complete and current; and (I-R, II-R, III-R, IV-R)

5. The data submitted by the STEMI centers shall be managed in compliance with the confidentiality requirements and procedures contained in section 192.067, RSMo. (I-R, II-R, III-R, IV-R)

**(3) Standards for Hospital Resources and Capabilities for STEMI Center Designation.**

(A) The STEMI center shall meet emergency department standards listed below.

1. The emergency department staffing shall meet the following requirements:

A. The emergency department in the STEMI center shall provide immediate and appropriate care of the STEMI patient; (I-R, II-R, III-R, IV-R)

B. A level I STEMI center shall have a medical director of the emergency department who shall be a board-certified or board-admissible physician in emergency medicine by the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada; (I-R)

C. A level II STEMI center shall have a medical director of the emergency department who shall be a board-certified or board-admissible physician; (II-R)

D. A level III and IV STEMI center shall have a medical director of the emergency department who is recommended to be a board-certified or board-admissible physician; (III-R, IV-R)

E. There shall be an emergency department physician credentialed for STEMI care covering the emergency department twenty-four (24) hours a day, seven (7) days a week; (I-R/IH, II-R/IH, III-R/IH, IV-R/IA)

F. The emergency department physician who provides coverage shall be current in continuing medical education (CME) in the area of cardiovascular disease as set forth in section (4) of this rule; (I-R/, II-R, III-R, IV-R/)

G. There shall be a written policy defining the organizational relationship of the emergency department physicians to other physician members of the STEMI team; (I-R, II-R, III-R, IV-R)

H. Registered nurses in the emergency department shall be current in continuing education requirements as set forth in section (4) of this rule; (I-R/, II-R, III-R, IV-R/)

I. At a minimum, all registered nurses assigned to the emergency department shall be determined to be credentialed in the care of the STEMI patient by the STEMI center within one (1) year of assignment in the emergency department, and these registered nurses shall remain current in continuing education requirements as set forth in section (4) of this rule; and (I-R, II-R, III-R, IV-R)

J. The emergency department in STEMI centers shall have written care protocols for identification, triage, and treatment of acute STEMI patients that are available to emergency department personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R, IV-R)

2. Nursing documentation for the STEMI patient shall be on a STEMI flow sheet approved by the STEMI medical director and the STEMI program manager/coordinator. (I-R, II-R, III-R, IV-R)

3. The emergency department shall have at least the following equipment for resuscitation and life support

available to the unit:

A. Airway control and ventilation equipment including:

(I) Laryngoscopes; (I-R, II-R, III-R, IV-R)

(II) Endotracheal tubes; (I-R, II-R, III-R, IV-R)

(III) Bag-mask resuscitator; (I-R, II-R, III-R, IV-R)

(IV) Sources of oxygen; and (I-R, II-R, III-R, IV-R)

(V) Mechanical ventilator; (I-R, II-R, III-R)

B. Suction devices; (I-R, II-R, III-R, IV-R)

C. Electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R, III-R, IV-R)

D. Central line insertion equipment; (I-R, II-R, III-R)

E. All standard intravenous fluids and administration devices including intravenous catheters and intraosseous devices; (I-R, II-R, III-R, IV-R)

F. Drugs and supplies necessary for STEMI emergency care; (I-R, II-R, III-R, IV-R)

G. Two- (2-) way communication link with emergency medical service (EMS) vehicles; (I-R, II-R, III-R, IV-R)

H. Equipment necessary to communicate with emergency medical services regarding pre-hospital ECG STEMI findings; (I-R, II-R, III-R, IV-R)

I. End-tidal carbon dioxide monitor; (I-R, II-R, III-R, IV-R)

J. Temperature control devices for patient and resuscitation fluids; (I-R, II-R, III-R, IV-R)

K. External pacemaker; and (I-R, II-R, III-R, IV-R)

L. Transvenous pacemaker. (I-R/IA, II-R/IA, III-R/IA)

4. The STEMI center emergency department shall maintain all equipment according to the hospital preventive maintenance schedule and document when the equipment is checked. (I-R, II-R, III-R, IV-R)

(D) The STEMI center shall have an intermediate care unit (e.g., step down unit). (I-R, II-R, III-R)

1. The STEMI center shall have a designated medical director for the STEMI center intermediate care unit who has access to a physician knowledgeable in STEMI care and who meets the STEMI call roster continuing medical education requirements as set forth in section (4) of this rule. (I-R, II-R, III-R)

2. The STEMI center intermediate care unit shall have a physician on duty or available twenty-four (24) hours a day, seven (7) days a week who is not the emergency department physician. This physician shall have access to a physician on the STEMI call roster. (I-R/IA, II-R/IA, III-R/IA)

3. The STEMI center intermediate care unit shall have registered nurses and other essential personnel on duty twenty-four (24) hours a day, seven (7) days a week. (I-R, II-R, III-R)

4. The STEMI center intermediate care unit registered nurses shall remain current in continuing education requirements as set forth in section (4) of this rule. (I-R/, II-R, III-R/)

5. The STEMI centers shall annually credential registered nurses that work in the intermediate care unit. (I-R, II-R, III-R)

6. The STEMI center intermediate care unit shall have written care protocols for identification and treatment of STEMI patients which are available to the cardiac unit personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R)

7. The STEMI center intermediate care unit shall have equipment to support the care and resuscitation of the STEMI patient that includes at least the following:

A. Airway control and ventilation equipment including:

(I) Laryngoscopes, endotracheal tubes of all sizes; (I-R, II-R, III-R)

(II) Bag-mask resuscitator and sources of oxygen; and (I-R, II-R, III-R)

(III) Suction devices; and (I-R, II-R, III-R)

B. Telemetry, electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R, III-R)

C. All standard intravenous fluids and administration devices and intravenous catheters; and (I-R, II-R, III-R)

D. Drugs and supplies necessary for emergency care. (I-R, II-R, III-R)

8. The STEMI center intermediate care unit shall maintain equipment according to the STEMI center's preventive maintenance schedule and document when the equipment is checked. (I-R, II-R, III-R)

(4) Continuing Medical Education (CME) and Continuing Education Standards for STEMI Center Designation.

(A) The STEMI center shall ensure that staff providing services to STEMI patients receive continued medical education and continuing education as set forth in section (4) of this rule and document this education for each staff member. The department shall allow up to one (1) year from the date of the STEMI center's initial STEMI center designation for STEMI center staff members to complete all of the required continuing medical education and/or continuing education requirements if the STEMI center staff documents that at least half of the required continuing medical education and continuing education hours have been completed for each STEMI center staff at the time of the on-site initial application review. The STEMI center shall submit documentation to the department within one (1) year of the initial designation date that all continued medical education and continuing education requirements for STEMI center staff members have been met in order to maintain the STEMI center's designation. (I-R[, II-R, III-R, IV-R])

(B) The STEMI call roster members shall complete the following continuing education requirements:

1. Core team members of the STEMI call roster in level I *[and level II]* STEMI centers shall document a minimum of *[ten (10)] eight (8)* hours every year of continuing education in the area of acute coronary syndrome. All other members of the STEMI call roster shall document a minimum of *[ten (10)] eight (8)* hours every year of continuing education in the area of cardiovascular disease, **except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department.** This continuing education shall be reviewed by the STEMI center medical director for appropriateness to the practitioner's level of responsibility; *and*]. (I-R[, II-R])

*[2. All members of the STEMI call roster in level III and level IV STEMI centers shall document a minimum of eight (8) hours every two (2) years of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed by the STEMI center medical director for appropriateness to the practitioner's level of responsibility. (III-R, IV-R)]*

(C) The STEMI center medical director shall complete the following continuing medical education requirements:

1. Level I *[and II]* STEMI medical directors shall document a minimum average of *[ten (10)] eight (8)* hours every year in the area of acute coronary syndrome;]. (I-R[, II-R])

*[2. The level III and IV STEMI medical directors that are board-certified or board-eligible shall document a minimum average of eight (8) hours every other year of continuing medical education in the area of cardiovascular disease; and (III-R, IV-R)]*

*3. The level III and IV STEMI medical directors who are not board-certified or board-eligible shall document:*

*A. A minimum average of ten (10) hours every two (2) years of continuing medical education in the area of cardiovascular disease with a focus on acute coronary syndrome; and (III-R, IV-R)*

*B. Attend one (1) national, regional, or state meeting every three (3) years in cardiovascular disease. Continuing medical education earned at these meetings can count toward the ten (10) continuing medical education hours required. (III-R, IV-R)]*

(D) The STEMI center's STEMI program manager/coordinator shall complete the following continuing education requirements:

1. A level I STEMI program coordinator/manager shall complete and document the following:

A. A minimum average of *[ten (10)] eight (8)* hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the STEMI program manager's/coordinator's level of responsibility; and (I-R)

B. Attend one (1) national, regional, or state meeting every two (2) years focused on cardiovascular disease. If the national, regional, or state meeting provides continuing education, that continuing education may count towards the annual requirement;]. (I-R)

*[2. A level II STEMI program coordinator/manager shall complete and document the following:*

*A. A minimum average of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed by the STEMI center medical director for appropriateness to the STEMI program manager's/coordinator's level of responsibility; and (II-R)*

*B. Attend one (1) national, regional, or state meeting every three (3) years focused on cardiovascular disease. If the national, regional, or state meeting provides continuing education, that continuing education may count toward the annual requirement; and (II-R)*

*3. The level III and IV STEMI program coordinator/manager shall complete and document a minimum average of eight (8) hours every other year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the STEMI program manager's/coordinator's level of responsibility. (III-R, IV-R)]*

(E) STEMI center emergency department personnel shall complete the continuing education requirements for STEMI centers that are detailed below.

1. The emergency department physician(s) shall be current in cardiovascular continuing medical education. (I-R[, II-R, III-R, IV-R])

A. Emergency department physicians in level I *[and II]* STEMI centers shall complete and document a minimum average of *[four (4)] two (2)* hours every year of continuing medical education in the area of cardiovascular disease, **except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department.** (I-R[, II-R])

*[B. Emergency department physicians in level III and IV STEMI centers shall complete and document a minimum average of six (6) hours every two (2) years of continuing medical education in the area of cardiovascular disease. (III-R, IV-R)]*

2. Registered nurses assigned to the emergency department shall complete the following requirements:

A. Registered nurses assigned to the emergency department at level I *[and II]* STEMI centers shall complete and document a minimum of *[four (4)] two (2)* hours of continuing education every year in the area of cardiovascular disease; **and** (I-R[, II-R])

*[B. Registered nurses assigned to the emergency department at level III and IV STEMI centers shall complete and*

document a minimum of six (6) hours of continuing education every two (2) years in the area of cardiovascular disease; and (III-R, IV-R)]

[C.B. Registered nurses assigned to the emergency department at STEMI centers shall maintain core competencies in the care of the STEMI patient annually as determined by the STEMI center. Continuing education earned in training to maintain these competencies may count toward continuing education requirements. (I-R, II-R, III-R, IV-R)

(F) Registered nurses assigned to the intensive care unit who provide care to STEMI patients shall complete the following continuing education requirements:

1. Registered nurses in the intensive care unit shall complete and document a minimum of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (I-R[, II-R]).

(G) Registered nurses and clinical staff assigned to the cardiac catheterization lab shall complete the following continuing education requirements:

1. Registered nurses and clinical staff shall complete and document a minimum of eight (8) hours of continuing education every year in the area of acute coronary syndrome. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (I-R[, II-R])

(H) Registered nurses assigned to the intermediate care unit shall complete the following continuing education requirements:

1. Intermediate care unit registered nurses in level I [and level II] STEMI centers shall complete and document a minimum of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility; and]. (I-R[, II-R])

[2. Intermediate care unit registered nurses in level III STEMI centers shall complete and document a minimum of eight (8) hours of continuing education every two (2) years in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (III-R)]

**AUTHORITY:** section[s] 190.185, **RSMo 2016**, and **section 190.241, RSMo Supp. [2012] 2022**. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

**PUBLIC COST:** This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.

**PRIVATE COST:** This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.

## TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE

### Division 2150 – State Board of Registration for the Healing Arts

#### Chapter 2 – Licensing of Physicians and Surgeons

#### EMERGENCY AMENDMENT

20 CSR 2150-2.080 Physician Licensure Fees. The board is

amending subsection (1)(A).

**PURPOSE:** This amendment updates physician licensure fees pursuant to section 135.690.3, **RSMo**.

**EMERGENCY STATEMENT:** During the 101st General Assembly, 2022, Senate Substitute for Senate Committee Substitute for House Bill 2331 was passed and became effective August 28, 2022. This piece of legislation created a tax credit under section 135.690, **RSMo**, for any community-based faculty preceptor who serves as the community-based faculty preceptor for a medical student core preceptorship. Funding for the tax credit program shall be generated from a license fee increase of seven dollars (\$7.00) per license for physicians and surgeons.

This emergency amendment is necessary to preserve a compelling governmental interest by establishing the fee necessary to support the administration of section 135.690, **RSMo**, by the Missouri Department of Health and Senior Services. Without this emergency amendment the seven dollar (\$7.00) per license fee requirement will not be effective in time for the January 1, 2023, effective date stated in section 135.690.3(1), **RSMo**.

As a result, the State Board of Registration for the Healing Arts finds that there is a compelling governmental interest that requires this emergency action. A proposed amendment that covers the same material is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri and United States Constitutions**. The State Board of Registration for the Healing Arts believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 30, 2022, becomes effective January 1, 2023, and expires June 29, 2023.

(1) The following fees are established by the State Board of Registration for the Healing Arts:

#### (A) Physician

- |                                      |            |
|--------------------------------------|------------|
| 1. Assistant Physician               |            |
| A. Licensure Fee                     | \$25       |
| B. Renewal Fee                       | \$25       |
| C. Prescriptive Authority Fee        | \$25       |
| 2. Contiguous State License          |            |
| A. Licensure Fee                     | \$25       |
| B. Renewal Fee                       | \$25       |
| 3. Limited License                   |            |
| A. Licensure Fee                     | \$25       |
| B. Renewal Fee                       | \$25       |
| 4. Permanent Physician               |            |
| A. Licensure Fee                     | [§75] \$82 |
| B. Reinstatement Fee                 | \$75       |
| C. Renewal Fee                       | \$100      |
| 5. Temporary Physician               |            |
| A. Conditional Temporary License Fee | \$25       |
| B. Temporary License Fee             | \$25       |
| C. Temporary Renewal Fee             | \$25       |
| 6. Visiting Professor                |            |
| A. Licensure Fee                     | \$25       |
| B. Renewal Fee                       | \$25       |

**AUTHORITY:** section 135.690, **RSMo Supp. 2022**, and sections 334.090.2 and 334.125, **RSMo 2016**. This rule originally filed as 4 CSR 150-2.080. Emergency rule filed July 1, 1981, effective July 11, 1981, expired Nov. 8, 1981. Original rule filed July 14, 1981, effective Oct. 11, 1981. Emergency amendment filed Nov. 30, 2022, effective Jan. 1, 2023, expires June 29, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.*

*PRIVATE COST: This emergency amendment will cost private entities eleven thousand one hundred thirty dollars (\$11,130) in the time the emergency is effective.*

**PRIVATE FISCAL NOTE****I. RULE NUMBER**

**Title 20 -Department of Commerce and Insurance**  
**Division 2150—State Board of Registration for the Healing Arts**  
**Chapter 2 – Licensing of Physicians and Surgeons**  
**Proposed Amendment to 20 CSR 2150-2.080 Physician Licensure Fees**

**II. SUMMARY OF FISCAL IMPACT**

<b>Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:</b>	<b>Classification by type of the business entities which would likely be affected:</b>	<b>Estimated costs for the life of the rule by affected entities:</b>
1,590	Permanent Physician Application ( Fee Increase @ \$7)	\$11,130
	<b>Estimated Cost Beginning in the time the emergency is effective</b>	<b>\$11,130</b>

**III. WORKSHEET**

See Table Above

**IV. ASSUMPTION**

1. The board is statutorily obligated to collect the seven dollar (\$7) preceptorship fee under section 339.690, RSMo. The revenue produced will be deposited in the Medical Preceptor Fund to be administered by the Department of Health and Senior Services.
2. Actual revenue increases may vary based on applications received.
3. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

**TITLE 20 – DEPARTMENT OF COMMERCE AND  
INSURANCE**

**Division 2150 – State Board of Registration for the  
Healing Arts  
Chapter 7 – Licensing of Physician Assistants**

**EMERGENCY AMENDMENT**

**20 CSR 2150-7.200 Physician Assistant Licensure Fees.** The board is amending section (1)(A).

*PURPOSE: This amendment updates physician assistant licensure fees pursuant to section 135.690.3, RSMo.*

*EMERGENCY STATEMENT: During the 101st General Assembly, 2022, Senate Substitute for Senate Committee Substitute for House Bill 2331 was passed and became effective August 28, 2022. This piece of legislation created a tax credit under section 135.690, RSMo, for any community-based faculty preceptor who serves as the community-based faculty preceptor for a physician assistant student core preceptorship. Funding for the tax credit program shall be generated from a license fee increase of three dollars (\$3.00) per license for physician assistants.*

*This emergency amendment is necessary to preserve a compelling governmental interest by establishing the fee necessary to support the administration of section 135.690, RSMo, by the Missouri Department of Health and Senior Services. Without this emergency amendment the three dollar (\$3.00) per license fee requirement will not be effective in time for the January 1, 2023, effective date stated in section 135.690.3(1), RSMo.*

*As a result, the State Board of Registration for the Healing Arts finds that there is a compelling governmental interest that requires this emergency action. A proposed amendment that covers the same material is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The State Board of Registration for the Healing Arts believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed November 30, 2022, becomes effective January 1, 2023, and expires June 29, 2023.*

(1) The following fees are established by the Missouri State Board of Registration for the Healing Arts in conjunction with the director of the Division of Professional Registration:

(A) Physician Assistant

1. Licensure Fee	<del>[\$25]</del> <b>\$28</b>
2. Renewal Fee	\$25
3. Temporary Licensure Fee	\$25
4. Temporary Licensure Renewal Fee	\$25
5. Certificate of Controlled Substance Prescriptive Authority Fee	\$25

*AUTHORITY: section 135.690, RSMo Supp. 2022, and sections 334.125, 334.735, 334.736, 334.738, and 334.743, RSMo 2016. This rule originally filed as 4 CSR 150-7.200. Emergency rule filed Sept. 15, 1992, effective Sept. 25, 1992, expired Jan. 22, 1993. Original rule filed April 2, 1992, effective Dec. 3, 1992. Emergency amendment filed Nov. 30, 2022, effective Jan. 1, 2023, expires June 29, 2023. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.*

*PRIVATE COST: This emergency amendment will cost private entities four hundred twenty dollars (\$420) in the time the emergency*

*is effective.*

**PRIVATE FISCAL NOTE****I. RULE NUMBER****Title 20 -Department of Commerce and Insurance****Division 2150—State Board of Registration for the Healing Arts****Chapter 7—Licensing of Physician Assistants****Proposed Amendment to 20 CSR 2150-7.200 Physician Assistant Licensure Fees****II. SUMMARY OF FISCAL IMPACT**

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated costs for the life of the rule by affected entities:
140	Physician Assistant Application ( Fee Increase @ \$3)	\$420
	<b>Estimated Cost in the time the emergency is effective</b>	<b>\$420</b>

**III. WORKSHEET**

See Table Above

**IV. ASSUMPTION**

1. The board is statutorily obligated to collect the three dollar (\$3) preceptorship fee under section 339.690, RSMo. The revenue produced will be deposited in the Medical Preceptor Fund to be administered by the Department of Health and Senior Services.
2. Actual revenue increases may vary based on applications received.
3. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo.

**EXECUTIVE ORDER  
22-07**

WHEREAS, on July 21st, 2022, I declared a drought alert for 53 counties through Executive Order 22-04; and

WHEREAS, Executive Order 22-04 is set to expire on December 1, 2022; and

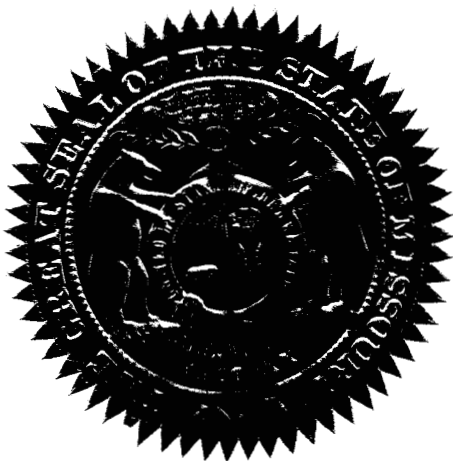
WHEREAS, the counties of Atchison, Barton, Bollinger, Boone, Cape Girardeau, Carroll, Cedar, Clay, Cooper, Dade, Dallas, Dunklin, Greene, Hickory, Howard, Jackson, Jasper, Johnson, Lafayette, Lawrence, McDonald, Mississippi, Moniteau, New Madrid, Newton, Pemiscot, Perry, Pettis, Platte, Polk, Saint Clair, Saline, Scott, Stoddard, Vernon, and Wayne continue to experience severe or extreme drought; and

WHEREAS, additional counties may enter severe, extreme, or exceptional drought according to the U.S. Drought Monitor and those counties shall also be declared in drought alert; and

WHEREAS, drought conditions remain such that the drought-response efforts described in Executive Order 22-04 are necessary to support continued mitigation; and

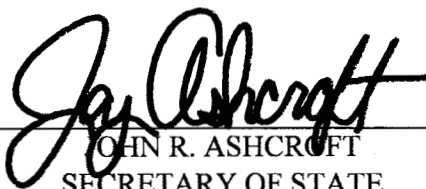
NOW, THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, by virtue and authority vested in me by the Constitution and laws of the State of Missouri, do hereby extend Executive Order 22-04 until March 1, 2023, unless terminated or extended by subsequent order.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 28th day of November, 2022.



  
MICHAEL L. PARSON  
GOVERNOR

ATTEST:

  
JOHN R. ASHCROFT  
SECRETARY OF STATE

The text of proposed rules and changes will appear under this heading. A notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This explanation is set out in the PURPOSE section of each rule. A citation of the legal authority to make rules is also required, and appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules that are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register*. If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close-of-comments date will be used as the beginning day in the ninety- (90-) day count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice, file a new notice of proposed rulemaking, and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:

**Boldface text indicates new matter.**

*[Bracketed text indicates matter being deleted.]*

## TITLE 1 – OFFICE OF ADMINISTRATION

### Division 10 – Commissioner of Administration

#### Chapter 3 – Preapproval of Claims and Accounts

#### PROPOSED AMENDMENT

**1 CSR 10-3.010 Preapproval of Claims/Accounts and Direct Deposit: Definitions/Examples.** The Office of Administration is amending section (3).

*PURPOSE: This proposed amendment modifies section (3) of the rule to clarify that an expense and equipment appropriation may be used for an unanticipated small dollar value maintenance, repair, minor modification, or capital improvement to a state-owned or leased facility or land, provided that such expenditure is approved by the directors of the Division of Facilities Management, Design and Construction and the Division of Accounting. This amendment increases the permissible amount of such expenditures, due to the cost of inflation. The amendment clarifies that expense and equip-*

*ment funds may not be used for any maintenance, repair, minor modification, or capital improvement if an appropriation for such work was not approved by the General Assembly.*

(3) The following are unallowable claims for the purpose of the appropriation charged:

(A) When the description of the claim indicates that the expenditure is not within the purpose of the appropriation being charged. For allowable claims, the following appropriation type definitions apply:

1. Expense and equipment – all expenditures for operating services, supplies, rentals, professional and technical services, other charges necessary to the operation of an agency, acquisition of equipment, and major repairs that extend the useful life of the equipment. *[This appropriation type also includes expenditures for operational repairs to state-owned facilities which do not increase their capacity or operating efficiency or enhance their function and are limited to ten thousand dollars (\$10,000) per project. Expense and equipment appropriations may also be used for capital improvements to offices and buildings up to ten thousand dollars (\$10,000) when no capital improvement appropriation exists and the expenditure is approved by the director of the Division of Facilities Management Design and Construction and the assistant director of the Division of Accounting. Expense and equipment appropriations do not include employee's wage/salaries, land acquisition, building acquisition, building construction, building demolition, and capital improvements other than those allowed above;]*

A. Expense and equipment may also include expenditures for unanticipated maintenance, repairs or minor modifications, or unanticipated capital improvements to a state-owned or leased facility or land that are limited to up to twenty thousand dollars (\$20,000) per project. Such expenditures must be approved in advance by the director of the Division of Facilities Management, Design and Construction and the director of the Division of Accounting. If a qualifying project under this section is necessary for the health and safety of the public and/or state employees and exceeds the twenty thousand dollar (\$20,000) threshold established above, the Commissioner of Administration may approve the use of an expense and equipment appropriation under this section up to thirty thousand dollars (\$30,000) per project. An expense and equipment appropriation may not be used for any maintenance, repair, modification, or capital improvement of a facility for which an appropriation was requested and not approved by the General Assembly.

B. Expense and equipment appropriations do not include employee's wage/salaries, land acquisition, building acquisition, building construction, building demolition, and capital improvements other than those allowed above.

C. As used herein, the following definitions apply:

I. Maintenance – preventative, routine, cyclical, and/or emergency unscheduled work necessary to keep in good working condition any facility, land, or equipment;

II. Repair – any work necessary to restore to good working condition any facility, land, or equipment; and

III. Minor modification – any alteration or improvement to a facility, land, or equipment that does not increase its capacity or operating efficiency or enhance its function;

2. Capital improvements – substantial expenditures for the purchase of capital assets (land and buildings) and the extensive repairs and improvements to a capital asset which increases its capacity or operating efficiency by extending its useful life and/or enhancing its function. *Purchase costs include purchase or contract price, delivered accessories, delivery*

charges, and other purchase-related costs. Extensive repair and improvement costs include materials and supplies directly related to the project and necessary to its completion and other related costs to the project];

3. Personal services – all expenditures for salaries, wages, and related employee benefits; and

4. Program/specific – expenses for a group of activities or services performed for an identifiable group to serve a specific purpose. This appropriation type allows any type of expenditure necessary to fulfill the intent of the program as defined in the corresponding house bill. Program appropriations may be broadly constructed or contain restrictive language for specific purposes;

*AUTHORITY: sections 33.030(3), 33.103, 370.395, and 536.023, RSMo 2016. Original rule filed Aug. 15, 1994, effective Jan. 29, 1995. Amended: Filed Oct. 3, 2018, effective May 30, 2019. Emergency amendment filed Feb. 11, 2020, effective Feb. 27, 2020, expired Aug. 24, 2020. Amended: Filed Feb. 11, 2020, effective Aug. 30, 2020. Amended: Filed Nov. 29, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Office of Administration, State Capitol Building, Room 125, PO Box 809, Jefferson City, MO 65102-0809. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

## **TITLE 2 – DEPARTMENT OF AGRICULTURE**

### **Division 90 – Weights, Measures and Consumer Protection**

#### **Chapter 21 – Weighing and Measuring Devices**

#### **PROPOSED AMENDMENT**

**2 CSR 90-21.010 Registration of Servicepersons and Service Agencies.** The department is amending sections (1) and (2), deleting sections (4) and (5), adding new sections (3)–(7), and renumbering as necessary.

*PURPOSE: This amendment will update the current language of the regulation to include the most current issue of the NIST Handbook 130, supplies definitions regarding registrations, and sets the cost to register service agencies and service agency technicians.*

(1) The rule for the Division of Weights, Measures and Consumer Protection for Voluntary Registration of Servicepersons and Service Agencies for Commercial Weighing and Measuring Devices shall incorporate by reference the section of the *NIST Handbook 130*, [2020] 2023 Edition, entitled “Uniform Regulation for the Voluntary Registration of Servicepersons and Service Agencies for Commercial Weighing and Measuring Devices.” **NIST Handbook 130, 2023 Edition, is published by the Superintendent of Documents, U.S. Government Publishing Office, and is available free of charge online at [www.NIST.gov](http://www.NIST.gov) or a hard copy may be purchased from the National Conference on Weights and Measures at [www.NCWM.net](http://www.NCWM.net).** This regulation does not include any later amendments or additions to *NIST Handbook 130*.

(2) [Registration Fee. There is no registration fee for Serviceper-

sons and Registered Service Agencies.] For the purposes of this regulation, the following terms shall mean –

(A) Calibration certificate – a certificate that indicates a mass or volume standard has a traceable calibration.

(B) Registration card – a card issued by the Division of Weights, Measures and Consumer Protection that indicates a serviceperson’s name, registration number, date of issuance, scope of work the person is allowed to perform, and the expiration date of the calibration certificate associated with the person’s equipment.

(C) Service agency – a company performing installation, repair, or calibration on a weighing or measuring device.

(D) Service work – installation, repair, or calibration performed on a weighing or measuring device that is placed into service for commercial purposes.

(E) Serviceperson – an employee of a service agency performing installation, repair, or calibration on a weighing or measuring device.

(3) Registration of Servicepersons and Service Agencies. Any serviceperson or service agency that places a weighing and measuring device into service or restores a device to service shall be registered with the Division of Weights, Measures and Consumer Protection. All registration applications are due to the division annually by July 1 and are to include a one hundred dollar (\$100) registration fee for any service agency and a twenty-five dollar (\$25) fee for every serviceperson. No registration card will be issued to a serviceperson or service agency that does not show a calibration certificate evidencing proof that they possess properly calibrated equipment.

(4) New Registrations. Any unregistered serviceperson or service agency can register with the division at any time during the calendar year but must do so before performing service work in this state.

(5) Registration Card Expiration. Registration cards shall expire annually on June 30 and may be renewed by that date to avoid expiration.

(6) Registration Card Renewal. Any serviceperson or service agency may renew their registration card by providing the appropriate fee and calibration certificate described in section (3) of this regulation.

(7) All service work performed on a weighing or measuring device shall be performed with calibrated equipment or shall be deemed invalid. Should the division determine that a device has been improperly placed into service, an official rejection tag shall be placed on the device until a proper placed-in-service report is received by the department.

[(3)](8) Placed-in-Service Report. Within twenty-four (24) hours after a device is restored to service or placed in service, the original of the properly executed [P]placed-in-[S]service Report, together with any official rejection tag removed from the device, shall be forwarded to MDA – Weights, Measures and Consumer Protection Division, PO Box 630, Jefferson City, MO 65102-0630 or faxed to (573[-]) 751-0281.

[(4) Certificate of Registration Exception. The “Certificate of Registration” will expire two (2) years from the date of issuance.

(5) *NIST Handbook 130, 2020 Edition, is published by the Superintendent of Documents, U.S. Government Publishing Office, and is available free of charge online at [NIST.gov](http://NIST.gov) or a hard copy may be purchased from the National Conference on*

---

*Weights and Measures at NCWM.net.]*

*AUTHORITY: section 413.065, RSMo 2016. Original rule filed Dec. 30, 1975, effective Jan. 9, 1976. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 23, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities thirty-two thousand two hundred fifty dollars (\$32,250) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Jimmy Williams at the Department of Agriculture by email at jimmy.williams@mda.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Missouri Department of Agriculture  
Division Title: Weights, Measures, and Consumer Protection  
Chapter Title: Agriculture**

<b>Rule Number and Title:</b>	2 CSR90-21
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
140	Fuel Dispenser and Scale Installers and Repairs	\$14,000.00
730	Servicepersons affiliated with the companies above	\$18,250.00

**III. WORKSHEET**

86	Number of Scale device companies	\$100 per Company	\$8,600.00
429	Number of Scale device company Servicepersons	\$25.00 per Serviceperson	\$10,725.00
54	Number of Fuel device companies	\$100 per Company	\$5,400.00
301	Number of Fuel device company Servicepersons	\$25.00 per Serviceperson	\$7,525.00
		Total	\$32,250.00

**IV. ASSUMPTIONS**

Using our current excel spreadsheet data we are able to determine how many companies are registered in Missouri and how many servicepersons are working in Missouri. These servicepersons install, repair, and/or calibrate weighing and measuring devices in Missouri and, by registering with the state, are allowed to place those devices into commercial use.

**TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 30 – Division of Regulation and Licensure  
Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

**PROPOSED AMENDMENT**

**19 CSR 30-40.410 Definitions and Abbreviations Relating to Trauma Centers.** The department is amending section (1).

*PURPOSE:* This amendment adds virtual reviews to the definitions for trauma centers.

(1) The following definitions and abbreviations shall be used in the interpretation of the rules in 19 CSR 30-40.400 to 19 CSR 30-40.450:

(II) Trauma team activation protocol is a hospital document outlining the criteria used to identify severely injured patients and the procedures for notification of trauma team members and indicating surgical and non-surgical specialty response times acceptable for treating major trauma patients; *[and]*

(JJ) Trauma triage is an estimation of injury severity at the scene of an accident~~;~~ *[and]*

(KK) **Virtual review means a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.**

*AUTHORITY:* section 190.185, RSMo [Supp. 2007] 2016, and section 190.241, [HB 1790, 94th General Assembly, Second Regular Session, 2008] RSMo Supp. 2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed Jan. 16, 2007, effective Aug. 30, 2007. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at Nicole.Gamm@health.mo.gov or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 30 – Division of Regulation and Licensure  
Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

**PROPOSED AMENDMENT**

**19 CSR 30-40.420 Trauma Center Designation Requirements.** The department is amending sections (2) and (3), renumbering throughout sections (2) and (3), and updating the application for trauma center designation from.

*PURPOSE:* This amendment decreases validation reviews to every

three (3) years, adds virtual review requirements, adds honorarium and payment requirements for virtual reviews and on-site reviews, adds qualified contractor requirements, updates language to be consistent with the House Bill 2331 amendment of sections 190.241 and 190.245, RSMo, that became effective August 28, 2022, adds a requirement that hospitals must provide the department with required medical records and quality improvement documentation or be revoked, allows hospitals to continue to be designated as long as the hospital has submitted an application, changes the requirements for hospitals participating in the local and regional emergency medical services systems, updates what the hospitals have to submit to the department to confirm verification or certification with national certifying bodies and when to submit changes of this verification or certification, removes the data submission requirement for hospitals verified by American College of Surgeons, and removes American College of Surgeons level IV trauma centers as an alternate designation since the American College of Surgeons has recently eliminated the level IV trauma center verification. This amendment also makes changes to the application for trauma center designation form included herein in subsection (3)(A) by removing the American College of Surgeons level IV trauma centers as an alternate designation and changing the certification section to reflect the new requirements for notification of changes and participation in the local and regional emergency medical services systems and removing the data submission requirement.

(2) Hospitals requesting to be reviewed and designated as a trauma center by the department shall meet the following requirements:

(F) The review of hospitals for trauma center designation shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **The department may conduct an on-site review, a virtual review or a combination thereof on the hospitals/trauma centers. For announced reviews that are scheduled with the hospitals/trauma centers, the department will make the hospitals/trauma centers aware at least thirty (30) days prior to the scheduled review whether the department intends that the review will be conducted on-site and/or virtually. Due to unforeseen circumstances, the department may need to change whether the review is conducted on-site and/or virtually less than thirty (30) days before the announced review. The department will contact the hospitals/trauma centers to make the hospitals/trauma centers aware of any changes about how the review will be conducted, either on-site and/or virtually, prior to the date of the announced review.** The cost of any and all site reviews shall be paid by each applicant hospital or renewing trauma center unless adequate funding is available to the department to pay for reviews~~;~~. **Hospitals/trauma centers shall be responsible for paying expenses related to the cost of the qualified contractors to review their respective hospitals/trauma centers during initial, validation, and focus reviews. The department shall be responsible for paying the expenses of its representative. Costs of the review to be paid by the hospital/trauma center include –**

1. An honorarium shall be paid to each qualified contractor of the review team whether the review occurs on-site or virtually. Qualified contractors of the review team for levels I and II trauma center reviews shall be paid one thousand four hundred fifty dollars (\$1,450) per reviewer. Qualified contractors of the review team for levels III and IV trauma center reviews shall be paid one thousand dollars (\$1,000) per reviewer. This honorarium shall be paid to each qualified contractor of the review team at the time the site survey begins if on-site or prior

to the beginning of the review if the review is conducted virtually;

2. Airfare shall be paid for each qualified contractor of the review team, if applicable;

3. Lodging shall be paid for each qualified contractor of the review team, unless the review is conducted virtually. The hospital/trauma center shall secure the appropriate number of hotel rooms for the qualified contractors and pay the hotel directly; and

4. Incidental expenses, if applicable, for each qualified contractor of the review team shall not exceed two hundred fifty dollars (\$250) and may include the following:

A. Airport parking;

B. Checking bag charges;

C. Meals during the review; and

D. Mileage to and from the review if no airfare was charged by the reviewer. If the reviewer solely participated virtually in the review and did not travel by vehicle to the review, then no mileage shall be paid. Mileage shall be paid at the federal mileage rate for business miles as set by the Internal Revenue Service (IRS). Federal mileage rates can be found at the website [www.irs.gov](http://www.irs.gov);

(G) For the purpose of reviewing trauma centers and hospitals applying for trauma center designation, the department shall use review teams consisting of two (2) surgeons and one (1) emergency physician who are experts in trauma care and one (1) trauma nurse coordinator/trauma program manager experienced in trauma center review. The team shall be disinterested politically and financially in the hospitals to be reviewed. Out-of-state review teams shall conduct levels I and II reviews. In-state reviewers may conduct level III reviews. In the event that out-of-state reviewers are unavailable, level II reviews may be conducted by in-state reviewers from emergency medical services (EMS) regions other than the region being reviewed with approval of the director of the Department of Health and Senior Services or his/her designee. When utilizing in-state review teams, the level II trauma center shall have the right to refuse one (1) review team[.].

1. Any individual interested in becoming a qualified contractor to conduct reviews shall –

A. Send the department a curriculum vitae (CV) or résumé that includes his or her experience and expertise in trauma care and whether an individual is in good standing with his or her licensing boards. A qualified contractor shall be in good standing with his or her respective licensing boards;

B. Provide the department evidence of his or her previous site survey experience (state and/or national designation survey process); and

C. Submit a list to the department that details any ownership he or she may have in a Missouri hospital(s), whether he or she has been terminated from any Missouri hospital(s), any lawsuits he or she has currently or had in the past with any Missouri hospital(s), and any Missouri hospital(s) for which his or her hospital privileges have been revoked.

2. Qualified contractors for the department shall enter into a written agreement with the department indicating that, among other things, they agree to abide by Chapter 190, RSMo, and the rules in this chapter, during the review process;

(J) Validation reviews shall occur every [five (5)] three (3) years;

(K) Hospitals/trauma centers being reviewed through a virtual survey shall do the following:

1. Provide a videoconferencing platform to be used for the hospital/trauma center virtual review;

2. Provide a live tour of the hospital;

3. Ensure the videoconferencing platform used during the review is compliant with state and federal laws for protected health information;

4. Assign an on-site visit coordinator for the review. The on-site visit coordinator role cannot be fulfilled by the trauma program manager. This on-site visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:

A. Scheduling the videoconferencing meetings;

B. Sending out calendar invitations;

C. Providing electronic medical record (EMR) access to designated individuals;

D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and

E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors, and the department;

5. Assign one (1) staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the trauma program manager, the trauma program medical director, the trauma program registrar, or the on-site visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR;

6. Provide the department with requested patient care report information for the review no later than thirty (30) days prior to the virtual review;

7. Provide the department with requested medical records, PIPS documentation, registry report and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;

8. Schedule a pre-review call with the qualified contractors, the department, the trauma program medical director, the trauma program manager, the staff navigators, and the on-site visit coordinator approximately one (1) week prior to the virtual review;

9. Test the functionality of the videoconferencing platform for the live tour of the hospital prior to the pre-review call; and

10. Provide a list of attendees for the review meeting and their roles to the review team and the department prior to the virtual review;

(L) The department may conduct an on-site review of the hospital prior to the virtual review to ensure that the hospital meets the requirements for trauma designation;

[(K)](M) Upon completion of a review, the reviewers shall submit a report of their findings to the department. The report shall state whether the specific standards for trauma center designation have or have not been met; if not met, in what way they were not met. The report shall include the patient chart audits and a narrative summary to include pre-hospital, hospital, trauma service, emergency department, operating room, recovery room, clinical lab, intensive care unit, blood bank, rehabilitation, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department has final authority to determine compliance with the rules of this chapter;

[(L)](N) Within thirty (30) days after receiving a review report, the department shall return a copy of the report in whole to the chief executive officer of the hospital reviewed. Included with the report shall be notification indicating that the hospital has met the criteria for trauma center designation or has failed to meet the criteria for the designation level for which it applied and options the hospital may pursue;

[(M)](O) If a verification review is required, the hospital shall

be allowed a period of six (6) months to correct deficiencies. A plan of correction form shall be provided to the department and shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings;

**[(N)](P)** Once a review is completed, a final report shall be prepared by the department. The final report shall be public record and shall disclose the standards by which the reviews were conducted and whether the standards were met. The reports filed by the reviewers shall be held confidential and shall be disclosed only to the hospital's chief executive officer or an authorized representative;

**[(O)](Q)** The department shall have the authority to put on probation, suspend, revoke, or deny trauma center designation if *[there is reasonable cause to believe]* **the department has determined** that there has been a substantial failure to comply with the requirements of the rules in this chapter. Once designated as a trauma center, a hospital may voluntarily surrender the designation at any time without giving cause, by contacting the department. In these cases, the application and review process shall be completed again before the designation may be reinstated;

**[(P)](R)** Trauma center designation shall be valid for a period of *[five (5)]* **three (3)** years from the date the trauma center is designated. Expiration of the designation shall occur unless the trauma center applies for validation review within this *[five- (5-)]* **three- (3-)** year period. Trauma center designation shall be site specific and not transferable when a trauma center changes location; *[and]*

**[(Q)](S)** The department shall investigate complaints against trauma centers. Failure of the hospital to cooperate in providing documentation and interviews with appropriate staff may result in revocation of trauma center designation. Any hospital~~[,]~~ which takes adverse action toward an employee for cooperating with the department regarding a complaint~~[,]~~ is subject to revocation of trauma center designation~~[,]~~; and

**(T)** Failure of a hospital/trauma center to provide all medical records and quality improvement documentation necessary for the department to conduct a trauma review in order to determine if the requirements of 19 CSR 30-40.430 have been met shall result in the revocation of the hospital/trauma center's designation as a trauma center.

(3) Hospitals seeking trauma center designation by the department based on their current verification as a trauma center by the American College of Surgeons shall meet the following requirements:

(B) *[Both sections A and B of t]*The application for trauma verified hospital designation form, included herein, shall be complete before the department designates a hospital/trauma center. The department shall notify the hospital/trauma center of any apparent omissions or errors in the completion of the application for trauma verified hospital designation form. Upon receipt of a completed and approved application, the department shall designate such hospital as follows:

1. The department shall designate a hospital as a level I trauma center if such hospital has been verified as a level I trauma center (adult and pediatric) by the American College of Surgeons;

2. The department shall designate a hospital as a level II trauma center if such hospital has been verified as a level II trauma center (adult and pediatric) by the American College of Surgeons;

3. The department shall designate a hospital as a level III trauma center if such hospital has been verified as a level III trauma center (adult and pediatric) by the American College of Surgeons;

*[4. The department shall designate a hospital as a level IV*

*trauma center if such hospital has been verified as a level IV trauma center (adult and pediatric) by the American College of Surgeons;]*

**[5.]4.** The department shall designate a hospital as a level I pediatric trauma center if such hospital has been verified as a level I pediatric trauma center (only treats children) by the American College of Surgeons;

**[6.]5.** The department shall designate a hospital as a level II pediatric trauma center if such hospital has been verified as a level II pediatric trauma center (only treats children) by the American College of Surgeons;

**[7.]6.** The department shall designate a hospital as a level I trauma center if such hospital has been verified as a level I trauma center (only treats adults) by the American College of Surgeons; and

**[8.]7.** The department shall designate a hospital as a level II trauma center if such hospital has been verified as a level II trauma center (only treats adults) by the American College of Surgeons;

**[(C)]** *Annually from the date of designation by the department submit to the department proof of verification as a trauma center by the American College of Surgeons and the names and contact information of the medical director of the trauma center and the program manager of the trauma center;*

**[(D)](C)** Within thirty (30) days of any changes **or receipt of a verification, the hospital shall** submit to the department proof of verification as a trauma center by the American College of Surgeons and the names and contact information of the medical director of the trauma center and the program manager of the trauma center. **Verification as a trauma center by the American College of Surgeons shall accompany the application for trauma verified hospital designation form. A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is verified as a trauma center by the American College of Surgeons for which the hospital used to receive its corresponding designation with the department as a trauma center, whether because the hospital voluntarily surrendered this verification or because the hospital's verification was suspended or revoked by the American College of Surgeons or expired;**

**[(E)]** *Submit to the department a copy of the verifying organization's final trauma center verification survey results within thirty (30) days of receiving such results;*

**(F)** *Submit to the department a completed application for trauma verified hospital designation form every three (3) years;*

**(G)** *Participate in the emergency medical services regional system of trauma care in its respective emergency medical services region as defined in 19 CSR 30-40.302;]*

**[(H)](D)** Participate in local and regional emergency medical services systems *[by reviewing and sharing outcome data and]* **for purposes of** providing training *[and]*, **sharing** clinical educational resources, **and collaborating on improving patient outcomes;**

**[(I)]** *Submit data to meet the data submission requirements in 19 CSR 30-40.430;]*

**[(J)](E)** The designation of a hospital as a trauma center pursuant to section (3) shall continue if such hospital retains verification as a trauma center by the American College of Surgeons; and

**[(K)](F)** The department may remove a hospital's designation as a trauma center if requested by the hospital or **if** the department determines that the verification by the American College of Surgeons has been suspended or revoked. The department may also remove a hospital's designation as a trauma center if the department determines the hospital's verification with the American College of Surgeons has expired. Any decision made by the department to withdraw the designation of

a trauma center that is based on the revocation or suspension of a verification by the American College of Surgeons shall not be subject to judicial review.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

SECTION OF HEALTH STANDARDS AND LICENSURE

**APPLICATION FOR TRAUMA VERIFIED HOSPITAL DESIGNATION**

In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a trauma center. Please complete all information.

ORGANIZATION'S TRAUMA IDENTIFICATION NUMBER

**CURRENT TRAUMA VERIFICATION ORGANIZATION AND LEVEL**

ADULT AND PEDIATRIC (TREATS ADULTS AND CHILDREN)	PEDIATRIC (TREATS CHILDREN ONLY)	ADULTS (TREATS ADULTS ONLY)
<input type="checkbox"/> Level I Trauma Center by the American College of Surgeons <input type="checkbox"/> Level II Trauma Center by the American College of Surgeons <input type="checkbox"/> Level III Trauma Center by the American College of Surgeons	<input type="checkbox"/> Level I Pediatric Trauma Center by the American College of Surgeons <input type="checkbox"/> Level II Pediatric Trauma Center by the American College of Surgeons	<input type="checkbox"/> Level I Trauma Center by the American College of Surgeons <input type="checkbox"/> Level II Trauma Center by the American College of Surgeons

**HOSPITAL INFORMATION**

NAME OF HOSPITAL (NAME TO APPEAR ON DESIGNATION CERTIFICATE)		TELEPHONE NUMBER
ADDRESS (STREET AND NUMBER)	CITY	ZIP CODE

**PROFESSIONAL INFORMATION**

CHIEF EXECUTIVE OFFICER	CHAIRMAN/PRESIDENT OF BOARD TRUSTEES
TRAUMA MEDICAL DIRECTOR (NAME, EMAIL, AND CONTACT PHONE NUMBER)	TRAUMA PROGRAM MANAGER (NAME, EMAIL, AND CONTACT PHONE NUMBER)

**The following should be submitted to the department as indicated**

- ☐ Proof of trauma verification with the American College of Surgeons with the expiration date of the verification.

**RESOURCE INFORMATION**

E.D. TRAUMA CASELOAD	TRAUMA TEAM ACTIVATIONS	C.T. SCAN CAPABILITY	M.R.I. CAPABILITY
OPERATING ROOMS	ICU/CCU BEDS	BURN BEDS	REHAB. BEDS
TRAUMA SURGEONS	NEUROSURGEONS	ORTHOPAEDISTS	E.D. PHYSICIANS
ANESTHESIOLOGISTS	C.R.N.A.s	PEDIATRICIANS	PEDIATRIC SURGEONS

**CERTIFICATION**

We, the undersigned hereby certify that:

- Within thirty (30) days of any changes or receipt of a verification, we will submit to the department proof of trauma verification with the American College of Surgeons.
- Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of our trauma center.
- Within thirty (30) days of the date that our hospital is no longer verified by the American College of Surgeons, whether because we voluntarily surrendered our verification or because our verification has been suspended or revoked by the American College of Surgeons or has expired, we will report this change in writing to the department.
- We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes.
- We understand that our designation as a trauma center by the department shall continue only if our hospital remains verified as a trauma center by the American College of Surgeons.

DATE OF APPLICATION
SIGNED (CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP)
SIGNED (HOSPITAL CHIEF EXECUTIVE OFFICER)
SIGNED (TRAUMA MEDICAL DIRECTOR)
SIGNED (DIRECTOR OF EMERGENCY MEDICINE)

*AUTHORITY: sections 190.176 and 190.185, RSMo 2016, and section 190.241, RSMo Supp. [2017] 2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions eighty-two thousand one hundred fifty dollars (\$82,150) during the three- (3-) year designation period.*

*PRIVATE COST: This proposed amendment will cost private entities twenty-six thousand two hundred dollars (\$26,200) during the three- (3-) year designation period.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at [Nicole.Gamm@health.mo.gov](mailto:Nicole.Gamm@health.mo.gov) or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, Missouri 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: Department of Health and Senior Services  
Division Title: Division of Regulation and Licensure  
Chapter Title: 19 CSR 30-40.420 Trauma Center Designation Requirements.**

<b>Rule Number and Title:</b>	<b>19 CSR 30-40.420 Trauma Center Designation Requirements</b>
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
5 hospitals/trauma centers virtual review costs	\$1,250 during the 3 year designation period
2 hospitals/trauma centers cost of reviews for qualified contractors for Level I and II trauma centers	\$2,900 during the 3 year designation period
3 hospitals/trauma centers cost of reviews for qualified contractors for Level II trauma centers	\$3,000 during the 3 year designation period
Department reviewer for trauma reviews	\$75,000
<b>TOTAL COSTS =</b>	<b>\$82,150 during the 3 year designation period</b>

**III. WORKSHEET**

Five (5) public hospitals/trauma centers reviewed during the three (3) year designation period X \$250.00 for virtual review cost = \$1,250 for the hospitals/trauma centers reviewed during the three (3) year designation period.

Two (2) public hospitals/trauma centers reviewed during the three (3) year designation period X \$1,450 for the cost of the reviews for the qualified contractors for Level I and II trauma centers = \$2,900 during the three (3) year designation period.

Three (3) public hospitals/trauma centers reviewed during the three (3) year designation period X \$1,000 for the cost of the reviews for the qualified contractors for Level III trauma centers = \$3,000 during the three (3) year designation period.

Department reviewer X 1 = \$75,000.

**IV. ASSUMPTIONS**

There are currently twenty-two (22) Level I-III trauma centers designated with the department. Seventeen (17) of these hospitals/trauma centers are private.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.720 will cost hospitals/trauma centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

There are two (2) public hospitals/trauma centers (Levels I and II) which will have to pay an additional \$1,450 for an additional review since the review period decreased from five (5) years to three (3) years.

There are three (3) public hospitals/trauma centers (Level III) which will have to pay an additional \$1,000 for an additional review since the review period decreased from five (5) years to three (3) years.

The department anticipates it will need one (1) additional nurse reviewer to complete the additional trauma reviews since the designation period decreased from five (5) years to (3) years. The department anticipates \$75,000 for this position with benefits.

The department is not including the costs to pay the reviewers/qualified contractors in this fiscal note because hospitals were already required to pay the costs of the reviewers/qualified contractors in the regulation. Additionally, the amount that the hospitals were paying for the reviewers/qualified contractors is not changing. The department is only including more detail about the payment information with the change in the regulation.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Department of Health and Senior Services**  
**Division Title: Division of Regulation and Licensure**  
**Chapter Title: 19 CSR 30-40.420 Trauma Center Designation Requirements.**

<b>Rule Number and Title:</b>	<b>19 CSR 30-40.420 Trauma Center Designation Requirements</b>
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
17 hospitals/trauma centers virtual review costs	\$4,250 during the 3 year designation period
11 hospitals/trauma centers cost of reviews for qualified contractors for Level I and II trauma centers	\$15,950 during the 3 year designation period
6 hospitals/trauma centers cost of reviews for qualified contractors for Level III trauma centers	\$6,000 during the 3 year designation period
<b>TOTAL COSTS =</b>	<b>\$26,200 during the 3 year designation period</b>

**III. WORKSHEET**

Seventeen (17) private hospitals/trauma centers reviewed during the three (3) year designation period X \$250.00 for virtual review cost = \$4,250 for the hospitals/trauma centers reviewed during the three (3) year designation period.

Eleven (11) private hospitals/trauma centers reviewed during the three (3) year designation period X \$1,450 for the cost of the reviews for the qualified contractors for Level I and II trauma centers = \$15,950 during the three (3) year designation period.

Six (6) private hospitals/trauma centers reviewed during the three (3) year designation period X \$1,000 for the cost of the reviews for the qualified contractors for Level III trauma centers = \$6,000 during the three (3) year designation period.

**IV. ASSUMPTIONS**

There are currently twenty-two (22) Level I-III trauma centers designated with the department. Seventeen (17) of these hospitals/trauma centers are private.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.720 will cost hospitals/trauma centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

There are eleven (11) private hospitals/trauma centers (Levels I and II) which will have to pay an additional \$1,450 for an additional review since the review period decreased from five (5) years to three (3) years.

There are six (6) private hospitals/trauma centers (Level III) which will have to pay an additional \$1,000 for an additional review since the review period decreased from five (5) years to three (3) years.

The department is not including the costs to pay the reviewers/qualified contractors in this fiscal note because hospitals were already required to pay the costs of the reviewers/qualified contractors in the regulation. Additionally, the amount that the hospitals were paying for the reviewers/qualified contractors is not changing. The department is only including more detail about the payment information with the change in the regulation.

## TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES

### Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations

#### PROPOSED AMENDMENT

#### 19 CSR 30-40.430 Standards for Trauma Center Designation.

The department is amending sections (1), (3), and (4) and renumbering as necessary.

*PURPOSE: This amendment changes continuing education hours/credentialing requirements to be consistent with required continuing education/credentialing requirements by the national verifying body for trauma centers, adds credentialing courses for nurses, changes EMS Bureau to department's time critical diagnosis unit, requires nurses in the ICU to be current in ATLS, updates the publication date for the National Trauma Data Standard, removes continuing medical education requirements for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine and who are practicing in the emergency department of a trauma center, removes requirements relating to the operation or construction of a helipad at trauma centers, and adds an option for trauma centers to enter trauma data into a national data registry or databank that will allow the trauma center to perform its performance improvement and patient safety program requirements.*

(1) General Standards for Trauma Center Designation.

*[(D) There shall be a lighted designated helicopter landing area at the trauma center to accommodate incoming medical helicopters. (I-R, II-R, III-R)]*

*1. The landing area shall serve solely as the receiving and take-off area for medical helicopters and shall be cordoned off at all times from the general public to assure its continual availability and safe operation. (I-R, II-R, III-R)]*

*2. The landing area shall be on the hospital premises no more than three (3) minutes from the emergency room. (I-R, II-R, III-R)]*

**(D) The trauma center shall have a helicopter landing area. (I-R, II-R, III-R)**

(E) The hospital shall appoint a board-certified surgeon to serve as the trauma medical director. (I-R, II-R, III-R)

1. There shall be a job description and organization chart depicting the relationship between the trauma medical director and other services. (I-R, II-R, III-R)

2. The trauma medical director shall be a member of the surgical trauma call roster. (I-R, II-R, III-R)

3. The trauma medical director shall be responsible for the oversight of the education and training of the medical and nursing staff in trauma care. (I-R, II-R, III-R)

4. The trauma medical director shall document *[a minimum average of sixteen (16)] thirty-six (36)* hours of continuing medical education (CME) in trauma care every *three (3)* years. (I-R, II-R, III-R)

5. The trauma medical director shall participate in the trauma center's research and publication projects. (I-R)

(F) There shall be a trauma nurse coordinator/trauma program manager. (I-R, II-R, III-R)

1. There shall be a job description and organization chart depicting the relationship between the trauma nurse coordinator/trauma program manager and other services. (I-R, II-R, III-R)

2. The trauma nurse coordinator/trauma program manager shall document *[a minimum average of sixteen*

*(16)] thirty-six (36)* hours of continuing nursing education in trauma care every *three (3)* years. (I-R, II-R, III-R)

*[(H) All members of the surgical trauma call roster and emergency medicine physicians including liaisons for anesthesiology, neurosurgery, and orthopedic surgery shall document a minimum average of eight (8) hours of CME in trauma care every year. In hospitals designated as adult/pediatric trauma centers, providing care to injured children fourteen (14) years of age and younger, four (4) of the eight (8) hours of education per year must be applicable to pediatric trauma. (I-R, II-R, III-R)]*

*[(I)](H) The hospital shall demonstrate that there is a plan for adequate post-discharge follow-up on trauma patients, including rehabilitation. (I-R, II-R, III-R)*

*[(J)](I) A [Missouri] trauma registry shall be completed on each patient who sustains a traumatic injury and meets the following criteria: Includes at least one (1) code within the range of the following injury diagnostic codes as defined in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9)-(CM) 800-959.9, which is incorporated by reference in this rule as published by the Centers for Disease Control and Prevention in 2006 and is available at National Center for Health Statistics, 1600 Clifton Road, Atlanta, GA 30333. This rule does not incorporate any subsequent amendments or additions. Excludes all diagnostic codes within the following code ranges: 905-909.9 (late effects of injury), 910-924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites), 930-939.9 (foreign bodies), and must include one (1) of the following criteria: hospital admission, patient transfer out of facility, or death resulting from the traumatic injury (independent of hospital admission or hospital transfer status). [The registry shall be submitted electronically in a format defined by the Department of Health and Senior Services.] Trauma centers shall enter trauma care data elements for each patient who meets these criteria. The trauma care data elements shall be those identified and defined by the National Trauma Data Standard, which is incorporated by reference in this rule as published by the American College of Surgeons in 2022 and is available at the American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)*

**1. Trauma centers shall enter trauma care data elements for each patient who meets the criteria above into the following:**

**A. Trauma centers shall submit data into the department's Missouri trauma registry. The data required in subsection (1)(I) above shall be submitted electronically into the Missouri trauma registry via the department's website at [www.health.mo.gov](http://www.health.mo.gov); or (I-R, II-R, III-R)**

**B. Trauma centers shall submit data into a national data registry or data bank capable of being used by the trauma center to perform its ongoing performance improvement and patient safety program requirements for its trauma patients. The trauma center shall submit data for each data element included in the national data registry or data bank's data system. (I-R, II-R, III-R)**

**2. Electronic data shall be submitted quarterly, ninety (90) days after the quarter ends. The trauma registry must be current and complete. (I-R, II-R, III-R)**

**3. Information provided by hospitals on the trauma registry shall be subject to the same confidentiality requirements and procedures contained in section 192.067, RSMo. (I-R, II-R, III-R)**

**(J) A patient log of those patients entered into the trauma registry with admission date, patient name, and injuries must be available for use during the site review process. [Information**

*provided by hospitals on the trauma registry shall be subject to the same confidentiality requirements and procedures contained in section 192.067, RSMo. The trauma care data elements shall be those identified and defined by the National Trauma Data Standard which is incorporated by reference in this rule as published by the American College of Surgeons in 2008 and is available at the American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions.]* (I-R, II-R, III-R)

(3) Standards for Special Facilities/Resources/Capabilities for Trauma Center Designation.

(A) The hospital shall meet emergency department standards for trauma center designation.

1. The emergency department staffing shall ensure immediate and appropriate care of the trauma patient. (I-R, II-R, III-R)

A. The physician director of the emergency department shall be board-certified or board-admissible in emergency medicine. (I-R, II-R)

B. There shall be a physician trained in the care of the critically injured as evidenced by credentialing in ATLS *[and current in trauma CME]* in the emergency department twenty-four (24) hours a day. ATLS is incorporated by reference in this rule as published by the American College of Surgeons in 2003 and is available at American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)

C. All emergency department physicians shall be certified in ATLS at least once. Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status. (I-R, II-R, III-R)

D. There shall be written protocols defining the relationship of the emergency department physicians to other physician members of the trauma team. (I-R, II-R, III-R)

E. All registered nurses assigned to the emergency department shall be credentialed in trauma nursing by the hospital within one (1) year of assignment. (I-R, II-R, III-R)

*[(I) Registered nurses credentialed in trauma nursing shall document a minimum of eight (8) hours of trauma-related continuing nursing education per year. (I-R, II-R, III-R)]*

*[(II)](I) Registered nurses credentialed in trauma care shall maintain current provider status in the **Trauma Care After Resuscitation (TCAR)**, Trauma Nurse Core Curriculum (TNCC), or Advanced Trauma Care for Nurses (ATCN) and either **Pediatric Care After Resuscitation (PCAR)**, Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS), or Emergency Nursing Pediatric Course (ENPC) within one (1) year of employment in the emergency department. The requirement for **Pediatric Care After Resuscitation**, Pediatric Advanced Life Support, Advanced Pediatric Life Support, or Emergency Nursing Pediatric Course may be waived in centers where policy exists diverting injured children to a pediatric trauma center and where a pediatric trauma center is adjacent and a performance improvement filter reviewing any children seen is maintained. The Trauma Nurse Core Curriculum is incorporated by reference in this rule as published in 2007 by the Emergency Nurses Association and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. Advanced Trauma Care for Nurses is incorporated by reference in this rule as published in 2003 by the Society of Trauma Nurses and is available at the Society of Trauma Nurses, 1926 Waukegan Road, Suite 100, Glenview, IL 60025. This rule does not incorporate any subsequent amendments or additions. Pediatric Advanced Life Support is incorporated by reference in this rule as published in 2005*

*by the American Heart Association and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. The Emergency Nursing Pediatric Course is incorporated by reference in this rule as published by the Emergency Nurses Association in 2004 and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. **Trauma Care After Resuscitation and Pediatric Care After Resuscitation are incorporated by reference in this rule as published in 2022 by TCAR Education Programs and are available at TCAR Education Programs, 33456 Havlik Drive, Scappoose, Oregon 97056. This rule does not incorporate any subsequent amendments or additions.*** (I-R, II-R, III-R)

2. Equipment for resuscitation and life support with age appropriate sizes for the critically or seriously injured shall include the following:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, sources of oxygen, and mechanical ventilator—I-R, II-R, III-R;

B. Suction devices—I-R, II-R, III-R;

C. Electrocardiograph, cardiac monitor, and defibrillator—I-R, II-R, III-R;

D. Central line insertion equipment—I-R, II-R, III-R;

E. All standard intravenous fluids and administration devices including intravenous catheters—I-R, II-R, III-R;

F. Sterile surgical sets for procedures standard for the emergency department—I-R, II-R, III-R;

G. Gastric lavage equipment—I-R, II-R, III-R;

H. Drugs and supplies necessary for emergency care—I-R, II-R, III-R;

I. Two-way radio linked with emergency medical service (EMS) vehicles—I-R, II-R, III-R;

J. End-tidal carbon dioxide monitor—I-R, II-R, III-R and mechanical ventilators—I-R, II-R;

K. Temperature control devices for patient, parenteral fluids, and blood—I-R, II-R, III-R; and

L. Rapid infusion system for parenteral infusion—I-R, II-R, III-R.

3. There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-R)

4. There shall be a designated trauma resuscitation area in the emergency department. (I-R, II-R)

5. There shall be X-ray capability with twenty-four (24)-hour coverage by technicians. (I-IH, II-IH, III-IA)

6. Nursing documentation for the trauma patient shall be on a trauma flow sheet approved by the trauma medical director and trauma nurse coordinator/trauma program manager. (I-R, II-R, III-R)

(B) The hospital shall meet intensive care unit (ICU) standards for trauma center designation.

1. There shall be a designated surgeon medical director for the ICU. (I-R, II-R, III-R)

2. A physician who is not the emergency department physician shall be on duty in the ICU or available in-house twenty-four (24) hours a day in a level I trauma center and shall be on call and available within twenty (20) minutes in a level II trauma center.

3. The minimum registered nurse/trauma patient ratio used shall be one to two (1:2). (I-R, II-R, III-R)

4. Registered nurses shall be credentialed in trauma care within one (1) year of assignment *[documenting a minimum of eight (8) hours of trauma-related continuing nursing education per year]*. (I-R, II-R, III-R)

5. Nursing care documentation shall be on a patient flow sheet. (I-R, II-R, III-R)

6. **Nurses assigned to the ICU shall maintain current provider status in ACLS.** At the time of the initial review, nurses assigned to ICU shall have successfully completed or be registered for a provider ACLS course. The requirement for ACLS may be waived in pediatric centers where policy exists diverting injured adults to an adult trauma center and where an adult trauma center is adjacent to the affected pediatric facilities, and a performance improvement filter reviewing any adult trauma patients seen is maintained. (I-R, II-R, III-R)[.]

7. There shall be separate pediatric and adult ICUs or a combined ICU with nurses trained in pediatric intensive care. In ICUs providing care to children, registered nurses shall maintain credentialing in PALS, APLS, or ENPC. (I-R, II-R)

8. There shall be beds for trauma patients or comparable level of care provided until space is available in ICU. (I-R, II-R, III-R)

9. Equipment for resuscitation and to provide life support for the critically or seriously injured shall be available for the intensive care unit. In ICUs providing care for the pediatric patient, equipment with age appropriate sizes shall also be available. This equipment shall include[,] but not be limited to:]-

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, and a mechanical ventilator – I-R, II-R, III-R;

B. Oxygen source with concentration controls – I-R, II-R, III-R;

C. Cardiac emergency cart, including medications – I-R, II-R, III-R;

D. Temporary transvenous pacemakers – I-R, II-R, III-R;

E. Electrocardiograph, cardiac monitor, and defibrillator – I-R, II-R, III-R;

F. Cardiac output monitoring – I-R, II-R;

G. Electronic pressure monitoring and pulse oximetry – I-R, II-R;

H. End-tidal carbon dioxide monitor and mechanical ventilators – I-R, II-R, III-R;

I. Patient weighing devices – I-R, II-R, III-R;

J. Temperature control devices – I-R, II-R, III-R;

K. Drugs, intravenous fluids, and supplies – I-R, II-R, III-R; and

L. Intracranial pressure monitoring devices – I-R, II-R.

10. There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-R)

(4) Standards for Programs in Performance Improvement and Improvement Patient Safety Program, Outreach, Public Education, and Training for Trauma Center Designation.

(F) There shall be a hospital-approved procedure for credentialing nurses in trauma care. (I-R, II-R, III-R)

1. All nurses providing care to severely injured patients and assigned to the emergency department or ICU shall complete a *[minimum of sixteen (16) hours of]* trauma nursing course[s] in order to become credentialed in trauma care. (I-R, II-R, III-R)

2. The content and format of any trauma nursing courses developed and offered by a hospital shall be developed in cooperation with the trauma medical director. A copy of the course curriculum used shall be filed with the *[EMS Bureau]* department's time critical diagnosis unit. (I-R, II-R, III-R)

3. Trauma nursing courses offered by institutions of higher education in Missouri such as the Advanced Trauma Care for Nurses, Emergency Nursing Pediatric Course, **Trauma Care After Resuscitation, Pediatric Care After Resuscitation**, or the Trauma Nurse Core Curriculum may be used to fulfill this requirement. To receive credit for this course, a nurse shall obtain advance approval for the course from the trauma

medical director and trauma nurse coordinator/trauma program manager and shall present evidence of satisfactory completion of the course. (I-R, II-R, III-R)

*AUTHORITY: section 190.185, RSMo [Supp. 2007] 2016, and section 190.241, [HB 1790, 94th General Assembly, Second Regular Session, 2008] RSMo Supp. 2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed Jan. 16, 2007, effective Aug. 30, 2007. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at Nicole.Gamm@health.mo.gov or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

## TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES

### Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations

#### PROPOSED AMENDMENT

**19 CSR 30-40.710 Definitions and Abbreviations Relating to Stroke Centers.** The department is amending section (1).

*PURPOSE: This amendment adds virtual reviews to the definitions for stroke centers.*

(1) As used in 19 CSR 30-40.720 and 19 CSR 30-40.730, the following terms shall mean:]-

(VV) Thrombolytics – drugs, including recombinant tissue plasminogen activator, used to dissolve clots blocking flow in a blood vessel. These thrombolytic drugs are used in the treatment of acute ischemic stroke and acute myocardial infarction; *[and]*

(WW) Transfer agreement – a document which sets forth the rights and responsibilities of two (2) hospitals regarding the inter-hospital transfer of patients[.]; **and**

**(XX) Virtual review – a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.**

*AUTHORITY: sections 192.006 and 190.185, RSMo [2000] 2016, and section[s] 190.185 and 190.241, RSMo Supp. [2012] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at Nicole.Gamm@health.mo.gov or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

#### **PROPOSED AMENDMENT**

**19 CSR 30-40.720 Stroke Center Designation Application and Review.** The department is amending sections (2) and (3), renumbering as necessary, and amending the application for stroke center designation form.

*PURPOSE: This amendment decreases validation reviews to every three (3) years, adds virtual review requirements, clarifies honorarium and payment requirements for virtual reviews, updates language to be consistent with the House Bill 2331 amendment of sections 190.241 and 190.245, RSMo, that became effective August 28, 2022, adds primary stroke center with thrombectomy capability as a type of certification or verification that hospitals may have in order for the department to designate hospitals as level II stroke centers, adds a requirement that hospitals must provide the department with required medical records and quality improvement documentation or be revoked, allows hospitals to continue to be designated as long as the hospital has submitted an application and the department has not yet been able to conduct a review, changes the requirements for hospitals participating in local and regional emergency medical services systems, removes the data submission requirement for hospitals certified or verified by department-approved national bodies and updates what the hospitals have to submit to the department to confirm verification or certification with national certifying bodies and when to submit changes of this verification or certification. This amendment also makes changes to the application for stroke center designation form included herein in subsection (3)(A) by adding primary stroke center with thrombectomy capability, changing the certification section to reflect the new requirements for notification of changes and participation in the local and regional emergency medical services systems, and removing the data submission requirement.*

(2) Hospitals requesting to be reviewed and designated as a stroke center by the department shall meet the following requirements:

(D) The department may conduct an on-site review, a virtual review, or a combination thereof on the hospitals/stroke centers. For announced reviews that are scheduled with the hospitals/stroke centers, the department will make the hospitals/stroke centers aware at least thirty (30) days prior to the scheduled review whether the department intends that the review will be conducted on-site and/or virtually. Due to unforeseen circumstances, the department may need to change whether the review is conducted on-site and/or virtually less than thirty (30) days before the announced review. The department will contact the hospitals/stroke centers to make the hospitals/stroke centers aware of any changes about how the review will be

conducted, either on-site and/or virtually, prior to the date of the announced review. The different types of [site] reviews to be conducted on hospitals/stroke centers seeking stroke center designation by the department include[;]–

1. An initial review shall occur on a hospital applying to be initially designated as a stroke center. An initial review shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **This review may occur on-site and/or virtually;**

2. A validation review shall occur on a designated stroke center applying for renewal of its designation as a stroke center. Validation reviews shall occur no less than every [four (4)] **three (3)** years. A validation review shall include interviews with designated stroke center staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **This review may occur on-site and/or virtually;** and

3. A focus review shall occur on a designated stroke center in which an initial or validation review was conducted and substantial deficiency(ies) were cited. A review of the physical plant will not be necessary unless a deficiency(ies) was cited in the physical plant in the preceding validation review. The focus review team shall be comprised of a representative from the department and may include a qualified contractor(s) with the required expertise to evaluate corrections in areas where deficiencies were cited. **This review may occur on-site and/or virtually;**

(E) Stroke center designation shall be valid for a period of [four (4)] **three (3)** years from the date the stroke center/hospital is designated. **Expiration of the designation shall occur unless the stroke center applies for validation review within this three- (3-) year period and the department is unable to conduct a review before the designation expires.**

1. Stroke center designation shall be site specific and non-transferable when a stroke center changes location.

2. Once designated as a stroke center, a stroke center may voluntarily surrender the designation at any time without giving cause, by contacting the department in writing. In these cases, the application and review process shall be completed again before the designation may be reinstated;

(H) Hospitals/stroke centers shall be responsible for paying expenses related to the cost of the qualified contractors to review their respective hospitals/stroke centers during initial, validation, and focus reviews. The department shall be responsible for paying the expenses of its representative. Costs of the review to be paid by the hospital/stroke center include[;]–

1. An honorarium shall be paid to each qualified contractor of the review team **whether the review occurs on-site or virtually.** Qualified contractors of the review team for levels I and II stroke center reviews shall be paid [six hundred dollars (\$600) for the day of travel per reviewer and eight hundred fifty dollars (\$850) for the day of the review] **one thousand four hundred fifty dollars (\$1,450)** per reviewer. Qualified contractors of the review team for levels III and IV stroke center reviews shall be paid [five hundred dollars (\$500) for the day of travel per reviewer and five hundred dollars (\$500) for the day of the review] **one thousand dollars (\$1,000)** per reviewer. This honorarium shall be paid to each qualified contractor of the review team at the time the site survey begins **if on-site or prior to the review beginning if the review is conducted virtually;**

2. Airfare shall be paid for each qualified contractor of the review team, if applicable;

3. Lodging shall be paid for each qualified contractor of the review team, **unless the review is conducted virtually.**

The hospital/stroke center shall secure the appropriate number of hotel rooms for the qualified contractors and pay the hotel directly; and

4. Incidental expenses, if applicable, for each qualified contractor of the review team shall not exceed two hundred fifty dollars (\$250) and may include the following:

- A. Airport parking;
- B. Checking bag charges;
- C. Meals during the review; and

D. Mileage to and from the review if no airfare was charged by the reviewer. **If the reviewer solely participated virtually in the review and did not travel by vehicle to the review, then no mileage shall be paid.** Mileage shall be paid at the federal mileage rate for business miles as set by the Internal Revenue Service (IRS). Federal mileage rates can be found at the website [www.irs.gov](http://www.irs.gov);

**(I) Hospitals/stroke centers being reviewed through a virtual survey shall do the following:**

1. Provide an audio and videoconferencing platform to be used for the hospital/stroke center virtual review;
2. Provide a live tour of the hospital;
3. Ensure the video and audio conferencing service used during the review is compliant with state and federal laws for protected health information;
4. Assign an on-site visit coordinator for the review. The on-site visit coordinator role cannot be fulfilled by the stroke program manager. This on-site visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:

- A. Scheduling the videoconferencing meetings;
- B. Sending out calendar invitations;
- C. Providing electronic medical record (EMR) access to designated individuals;
- D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and

E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors, and the department;

5. Assign one (1) staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the stroke program manager, the stroke program medical director, the stroke program registrar, or the on-site visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR;

6. Provide the department with requested patient care report information for the review through a method that is compliant with state and federal laws for protected health information no later than thirty (30) days prior to the virtual review;

7. Provide the department with requested medical records, PIPS documentation, registry report, and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;

8. Schedule a pre-review call with the qualified contractors, the department, the stroke program medical director, the stroke program manager, the staff navigators, and the on-site visit coordinator approximately one (1) week prior to the virtual review;

9. Test the functionality of the audio and videoconferencing service for the live tour of the hospital prior to the pre-review call; and

10. Provide a list of attendees for the review meeting and their roles to the review team and the department pri-

or to the virtual review;

**(J) The department may conduct an on-site review of the hospital prior to the virtual review to ensure that the hospital meets the requirements for stroke designation;**

**[(I)](K)** Upon completion of a review, the qualified contractors from the review team shall submit a report of their findings to the department. This report shall state whether the specific standards for stroke center designation have or have not been met and if not met, in what way they were not met. This report shall detail the hospital/stroke center's strengths, weaknesses, deficiencies, and recommendations for areas of improvement. This report shall also include findings from patient chart audits and a narrative summary of the following areas: prehospital, hospital, stroke service, emergency department, operating room, angiography suites, recovery room, clinical lab, intensive care unit, rehabilitation, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department shall have the final authority to determine compliance with the rules of this chapter;

**[(J)](L)** The department shall return a copy of the report to the chief executive officer, the stroke medical director, and the stroke program manager/coordinator of the hospital/stroke center reviewed. Included within the report shall be notification indicating whether the hospital/stroke center has met the criteria for stroke center designation or has failed to meet the criteria for the stroke center designation requested. Also, if a focus review of the stroke center is required, the time frame for this focus review will be shared with the chief executive officer, the stroke medical director, and the stroke program manager/coordinator of the stroke center reviewed;

**[(K)](M)** When the hospital/stroke center is found to have deficiencies, the hospital/stroke center shall submit a plan of correction to the department. The plan of correction shall include identified deficiencies, actions to be taken to correct deficiencies, time frame in which the deficiencies are expected to be resolved, and the person responsible for the actions to resolve the deficiencies. A plan of correction form shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings and designation. If a focus review is required, then the stroke center shall be allowed a minimum period of six (6) months to correct deficiencies;

**[(L)](N)** A stroke center shall make the department aware in writing within thirty (30) days if there are any changes in the stroke center's name, address, contact information, chief executive officer, stroke medical director, or stroke program manager/coordinator;

**(O) Failure of a hospital/stroke center to provide all medical records and quality improvement documentation necessary for the department to conduct a stroke review in order to determine if the requirements of 19 CSR 30-40.730 have been met shall result in the revocation of the hospital/stroke center's designation as a stroke center;**

**[(M)](P)** Any person aggrieved by an action of the Department of Health and Senior Services affecting the stroke center designation pursuant to Chapter 190, RSMo, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination thereon by the Administrative Hearing Commission under Chapter 621, RSMo. It shall not be a condition to such determination that the person aggrieved seek reconsideration, a rehearing, or exhaust any other procedure within the department; and

**[(N)](Q)** The department may deny, place on probation, suspend, or revoke such designation in any case in which it has *[reasonable cause to believe]* determined that there has been a substantial failure to comply with the provisions of Chapter

190, RSMo, or any rules or regulations promulgated pursuant to this chapter. If the Department of Health and Senior Services has *[reasonable cause to believe]* **determined** that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site reviews of the hospital to verify compliance. If a stroke center fails two (2) consecutive on-site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245, RSMo, or rules adopted by the department pursuant to sections 190.001 to 190.245, RSMo, its center designation shall be revoked.

(3) Hospitals seeking stroke center designation by the department based on their current certification **or verification** as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall meet the following requirements:

(A) An application for stroke center designation by the department for hospitals that have been certified **or verified** as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to make a determination of eligibility for review and designation in accordance with the rules of this chapter. The application for stroke certified hospital designation form, included herein, is available at the Health Standards and Licensure (HSL) office, or online at the department's website at [www.health.mo.gov](http://www.health.mo.gov), or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for stroke center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation *[or expiration of the current designation]*;

(B) Both sections A and B of the application for stroke certified hospital designation form, included herein, shall be complete before the department designates a hospital/stroke center. The department shall notify the hospital/stroke center of any apparent omissions or errors in the completion of the application for stroke certified hospital designation form. Upon receipt of a completed and approved application, the department shall designate such hospital as follows:

1. The department shall designate a hospital a level I stroke center if such hospital has been certified as a comprehensive stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program;

2. The department shall designate a hospital a level II stroke center if such hospital has been certified as a primary stroke center **with thrombectomy capability or a primary stroke center** by either the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program; or

3. The department shall designate a hospital a level III stroke center if such hospital has been certified as an acute stroke-ready center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program;

*[(C) Annually from the date of designation by the department, submit to the department proof of certification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program and the names and contact information of the medical director of the stroke center and the program manager of the stroke center;]*

*[(D)](C) Within thirty (30) days of any changes **or receipt of a certificate or verification**, the hospital shall submit[,] to the department proof of certification or verification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program and the names and contact information of the medical director of the stroke*

*center and the program manager of the stroke center. A certificate or verification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall accompany the application for stroke certified hospital designation form. A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is certified or verified as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program for which the hospital used to receive its corresponding designation with the department as a stroke center, whether because the hospital voluntarily surrendered this certificate or verification or because the hospital's certificate or verification was suspended or revoked by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program or expired;*

*[(E) Submit to the department a copy of the certifying organization's final stroke certification survey results within thirty (30) days of receiving such results;*

*(F) Submit to the department a completed application for stroke certified hospital designation form every four (4) years;*

*(G) Participate in the emergency medical services regional system of stroke care in its respective emergency medical services region as defined in 19 CSR 30-40.302;]*

*[(H)](D) Any hospital designated as a level III stroke center that is certified **or verified** by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program as an acute stroke-ready center shall have a formal agreement with a level I or level II stroke center designated by the department for physician consultative services for evaluation of stroke patients for thrombolytic therapy and the care of the patient post-thrombolytic therapy;*

*[(I)](E) Participate in local and regional emergency medical services systems *[by reviewing and sharing outcome data and] for purposes of providing training [and], sharing* clinical educational resources, **and collaborating on improving patient outcomes**;*

*[(J) Submit data to meet the data submission requirements outlined in 19 CSR 30-40.730(1)(Q);]*

*[(K)](F) The designation of a hospital as a stroke center pursuant to section (3) shall continue if such hospital retains certification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program; and*

*[(L)](G) The department may remove a hospital's designation as a stroke center if requested by the hospital or the department determines that the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program certification **or verification** has been suspended or revoked. Any decision made by the department to withdraw the designation of a stroke center that is based on the revocation or suspension of a certification **or revocation** by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall not be subject to judicial review.*



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION OF HEALTH STANDARDS AND LICENSURE

**APPLICATION FOR STROKE CERTIFIED HOSPITAL DESIGNATION**

<b>SECTION A</b>		
In accordance with the requirements of the Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a stroke center. Please complete all information.		ORGANIZATION'S STROKE IDENTIFICATION NO.
CURRENT STROKE CERTIFICATION ORGANIZATION		
<input type="checkbox"/> The Joint Commission <input type="checkbox"/> DNV-GL Healthcare <input type="checkbox"/> Healthcare Facilities Accreditation Program		
CURRENT STROKE CERTIFICATION LEVEL		
<input type="checkbox"/> Comprehensive Stroke Center <input type="checkbox"/> Primary Stroke Center with Thrombectomy Capability <input type="checkbox"/> Primary Stroke Center <input type="checkbox"/> Acute Stroke-Ready Center		
<b>HOSPITAL INFORMATION</b>		
NAME OF HOSPITAL (NAME TO APPEAR ON DESIGNATION CERTIFICATE )		TELEPHONE NUMBER
ADDRESS (STREET AND NUMBER)	CITY	ZIP CODE
<b>PROFESSIONAL INFORMATION</b>		
CHIEF EXECUTIVE OFFICER	CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES	
STROKE MEDICAL DIRECTOR (NAME, EMAIL, AND CONTACT PHONE NUMBER)	STROKE PROGRAM MANAGER (NAME, EMAIL, AND CONTACT PHONE NUMBER)	
<b>SECTION B</b>		
The following should be submitted to the department as indicated:		
<input type="checkbox"/> Proof of stroke certification with the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program.		
If applying for Acute Stroke-Ready/Level III Stroke Center designation, the following should be submitted to the Department:		
<input type="checkbox"/> Formal agreement with Level I or Level II stroke center for physician consultative services for evaluation of stroke patients for thrombolytic therapy and the care of the patients' post-thrombolytic therapy.		
<b>CERTIFICATION</b>		
We, the undersigned, hereby certify that:		
A. Within thirty (30) days of any changes or receipt of a certificate or verification, we will submit to the department proof of stroke certification with the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program. B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of our stroke center. C. Within thirty (30) days of the date that our hospital is no longer certified or verified by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program, whether because we voluntarily surrendered our certification or verification or because our certification or verification has been suspended or revoked by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program or expired, we will report this change in writing to the department. D. We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes. E. We understand that our designation as a stroke center by the department shall continue only if our hospital remains certified as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program.		
SIGNATURE OF CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP		
SIGNATURE OF HOSPITAL CHIEF EXECUTIVE OFFICER		
SIGNATURE OF STROKE MEDICAL DIRECTOR		
SIGNATURE OF DIRECTOR OF EMERGENCY MEDICINE	DATE	

*AUTHORITY: sections 190.185 and 192.006, RSMo 2016, and section 190.241, RSMo Supp. [2017] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Aug. 7, 2017, effective Aug. 17, 2017, expired Feb. 22, 2018. Amended: Filed Aug. 7, 2017, effective March 30, 2018. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.*

*PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions ninety-seven thousand six hundred dollars (\$97,600) during the three- (3-) year designation period.*

*PRIVATE COST: This proposed amendment will cost private entities twenty-seven thousand two hundred fifty dollars (\$27,250) during the three- (3-) year designation period.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at [Nicole.Gamm@health.mo.gov](mailto:Nicole.Gamm@health.mo.gov) or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: Department of Health and Senior Services**  
**Division Title: Division of Regulation and Licensure**  
**Chapter Title: 19 CSR 30-40.720 Stroke Center Designation Application and Review.**

<b>Rule Number and Title:</b>	<b>19 CSR 30-40.720 Stroke Center Designation Application and Review</b>
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Seventeen (17) hospitals/stroke centers for virtual review costs	\$4,250 during the 3 year designation period
3 hospitals/stroke centers cost of reviews for qualified contractors for Level I and II reviews	\$4,350 during the 3 year designation period
14 hospitals/stroke centers cost of reviews for qualified contractors for Level III and IV reviews	\$14,000 during the 3 year designation period
Department reviewer for stroke reviews	\$75,000
<b>TOTAL COSTS =</b>	<b>\$97,600 during the 3 year designation period</b>

**III. WORKSHEET**

Seventeen (17) public hospitals/stroke centers reviewed during the three (3) year designation period X \$250.00 for the virtual review costs = \$4,250 for the hospitals/stroke centers reviewed during the three (3) year designation period.

Three (3) public hospitals/stroke centers reviewed during the three (3) year designation period X \$1,450 for the cost of the reviews for the qualified contractors for Level I and II reviews = \$4,350 during the three (3) year designation period.

Fourteen (14) public hospitals/stroke centers reviewed during the three (3) year designation period X \$1,000 for the cost of the reviews for the qualified contractors for Level III and IV reviews = \$14,000 during the three (3) year designation period.

Department reviewer X 1 = \$75,000.

**IV. ASSUMPTIONS**

There are currently thirty-seven (37) Level I-IV stroke centers designated with the department. Seventeen (17) of those hospitals are public hospitals and will be reviewed during the three (3) year designation period.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.720 will cost hospitals/stroke centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

There are three (3) public hospitals/stroke centers (Levels I and II) which will have to pay an additional \$1,450 for an additional review since the review period decreased from four (4) years to three (3) years.

There are fourteen (14) public hospitals/stroke centers (Levels III and IV) which will have to pay an additional \$1,000 for an additional review since the review period decreased from four (4) years to three (3) years.

The department anticipates it will need one (1) additional nurse reviewer to complete the additional stroke reviews since the designation period decreased from four (4) years to (3) years. The department anticipates \$75,000 for this position with benefits.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Department of Health and Senior Services**  
**Division Title: Division of Regulation and Licensure**  
**Chapter Title: 19 CSR 30-40.720 Stroke Center Designation Application and Review.**

<b>Rule Number and Title:</b>	<b>19 CSR 30-40.720 Stroke Center Designation Application and Review</b>
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Twenty (20) hospitals/stroke centers for virtual review costs	\$5,000 during the 3 year designation period
Five (5) hospitals/stroke centers for Level I and II reviews	\$7,250 during the 3 year designation period
Fifteen (15) hospitals/stroke centers for Level III and IV reviews	\$15,000 during the 3 year designation period
<b>TOTAL COSTS =</b>	<b>\$27,250 during the 3 year designation period</b>

**III. WORKSHEET**

Twenty (20) private hospitals/stroke centers reviewed during the three (3) year designation period X \$250.00 for virtual review costs = \$5,000 for the hospitals/stroke centers reviewed during the three (3) year designation period.

Five (5) private hospitals/stroke centers reviewed during the three (3) year designation period X \$1,450 for the cost of the reviews for the qualified contractors for Level I and II reviews= \$7,250 during the three (3) year designation period.

Fifteen (15) private hospitals/stroke centers reviewed during the three (3) year designation period X \$1,000 for the cost of the reviews for the qualified contractors for Level III and IV reviews = \$15,000 during the three (3) year designation period.

**IV. ASSUMPTIONS**

There are currently thirty-seven (37) Level I-IV stroke centers designated with the department. Twenty (20) of those hospitals are private hospitals and will be reviewed during the three (3) year designation period. Five (5) of the private hospitals are Level I and II stroke centers designated by the department and will be required to pay \$1,450 for

a review every three (3) years. Fifteen (15) of the private hospitals are Level III and IV stroke centers and will be required to pay \$1,000 for a review every three (3) years.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.720 will cost hospitals/stroke centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

**TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES****Division 30 – Division of Regulation and Licensure  
Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations****PROPOSED AMENDMENT****19 CSR 30-40.730 Standards for Stroke Center Designation.**

The department is amending sections (1), (3), and (4) and renumbering as necessary.

*PURPOSE: This amendment changes continuing education hours to be consistent with required continuing education requirements by national designating or verifying bodies of stroke centers, removes continuing medical education requirements for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine and who are practicing in the emergency department of a stroke center, removes requirements relating to the operation or construction of a helipad at stroke centers, and adds an option for stroke centers to enter stroke data into an national data registry or databank that will allow the stroke center to perform its performance improvement and patient safety program requirements.*

**(1) General Standards for Stroke Center Designation.**

(F) The stroke center shall appoint a physician to serve as the stroke medical director. A stroke medical director shall be appointed at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. A level I stroke medical director shall have appropriate qualifications, experience, and training. A board-certified or board-admissible neurologist or other neuro-specialty trained physician is recommended. If the stroke medical director is board-certified or board-admissible, then one (1) of the following additional qualifications shall be met and documented. If the stroke medical director is not board-certified, then two (2) of the following additional qualifications shall be met and documented:

A. Completion of a stroke fellowship; (I-R)

B. Participation (as an attendee or faculty) in one (1) national or international stroke course or conference each year or two (2) regional or state stroke courses or conferences each year; or (I-R)

C. Five (5) or more peer-reviewed publications on stroke. (I-R)

2. A level II stroke medical director shall have appropriate qualifications, experience, and training. A board-certified or board-admissible physician with training and expertise in cerebrovascular disease is recommended. If the stroke medical director is board-certified or board-admissible, then one (1) of the following additional qualifications shall be met. If the stroke medical director is not board-certified, then two (2) of the following additional qualifications shall be met and documented:

A. Completion of a stroke fellowship; (II-R)

B. Participation (as an attendee or faculty) in one (1) national or international stroke course or conference each year or two (2) regional or state stroke courses or conferences each year; or (II-R)

C. Five (5) or more peer-reviewed publications on stroke. (II-R)

3. A level III and IV stroke medical director shall have the appropriate qualifications, experience, and training. A board-certified or board-admissible physician is recommended. If the stroke medical director is not board-certified or board-admissible, then the following additional qualifications shall be met and documented:

A. Complete a minimum of *[ten (10)] four (4)* hours of continuing medical education (CME) in the area of cerebrovascular disease every *[other]* year; and (III-R, IV-R)

B. Attend one (1) national, regional, or state meeting every three (3) years in cerebrovascular disease. Continuing medical education hours earned at these meetings can count toward the *[ten (10)] four (4)* required continuing medical education hours **for level III stroke medical directors.** (III-R, IV-R)

4. The stroke medical director shall meet the department's continuing medical education requirements for stroke medical directors as set forth in section (4) of this rule. (I-R, II-R, III-R, IV-R)

5. The stroke center shall have a job description and organizational chart depicting the relationship between the stroke medical director and the stroke center services. (I-R, II-R, III-R, IV-R)

6. The stroke medical director is encouraged to be a member of the stroke call roster. (I-R, II-R, III-R, IV-R)

7. The stroke medical director shall be responsible for the oversight of the education and training of the medical and clinical staff in stroke care. This includes a review of the appropriateness of the education and training for the practitioner's level of responsibility. (I-R, II-R, III-R, IV-R)

8. The stroke medical director shall participate in the stroke center's research and publication projects. (I-R)

(P) The stroke center shall have a helicopter landing area. (I-R, II-R, III-R, IV-R)

*[1. Level I and II stroke centers shall have a lighted designated helicopter landing area at the stroke center to accommodate incoming medical helicopters. (I-R, II-R)]*

*A. The landing area shall serve solely as the receiving and take-off area for medical helicopters and shall be cordoned off at all times from the general public to assure its continual availability and safe operation. (I-R, II-R)]*

*B. The landing area shall be on the hospital premises no more than three (3) minutes from the emergency room. (I-R, II-R)]*

*2. Level III and IV stroke centers shall have a lighted designated helicopter landing area that meets the following requirements:*

*A. Accommodates incoming medical helicopters; (III-R, IV-R)]*

*B. Serves as the receiving and take-off area for medical helicopters; (III-R, IV-R)]*

*C. Be cordoned off when in use from the general public; (III-R, IV-R)]*

*D. Be managed to assure its continual availability and safe operation; and (III-R, IV-R)]*

*E. Though not required, it is recommended the landing area be no more than three (3) minutes from the emergency department. (III-R, IV-R)]*

(Q) Stroke centers shall enter data into *[the Missouri]* a stroke registry as follows:

1. *[All s]*Stroke centers shall submit data into the department's Missouri stroke registry on each stroke patient who is admitted to the stroke center, transferred out of the stroke center, or dies as a result of the stroke (independent of hospital admission or hospital transfer status). The data required to be submitted into the Missouri stroke registry by the stroke centers is listed and explained in the document entitled "Time Critical Diagnosis Stroke Center Registry Data Elements," dated March 1, 2012, which is incorporated by reference in this rule and is available at the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570 or on the department's website at [www.health.mo.gov](http://www.health.mo.gov). This rule does not incorporate any subsequent amendments or additions; (I-R, II-R, III-R, IV-R)].

[2.] The data [required in paragraph (1)(Q)1. above] shall be submitted electronically into the Missouri stroke registry via the department's website at [www.health.mo.gov](http://www.health.mo.gov); or (I-R, II-R, III-R, IV-R)

**2. Stroke centers shall submit data into a national data registry or data bank capable of being used by the stroke center to perform its ongoing performance improvement and patient safety program requirements for its stroke patients. The stroke center shall submit data for each data element included in the national data registry or data bank's data system; (I-R, II-R, III-R, IV-R)**

3. The data required in paragraphs (1)(Q)1. and 2. above shall be submitted electronically into the [Missouri] stroke registry on at least a quarterly basis for that calendar year. Stroke centers have ninety (90) days after the quarter ends to submit the data electronically into the [Missouri] stroke registry; (I-R, II-R, III-R, IV-R)

4. The data submitted by the stroke centers shall be complete and current; and (I-R, II-R, III-R, IV-R)

5. The data shall be managed in compliance with the confidentiality requirements and procedures contained in section 192.067, RSMo. (I-R, II-R, III-R, IV-R)

(3) Standards for Hospital Resources and Capabilities for Stroke Center Designation.

(A) The stroke center shall meet emergency department standards listed below. (I-R, II-R, III-R, IV-R)

1. The emergency department staffing shall meet the following requirements:

A. The emergency department in the stroke center shall provide immediate and appropriate care for the stroke patient; (I-R, II-R, III-R, IV-R)

B. A level I stroke center shall have a medical director of the emergency department who shall be board-certified or board-admissible in emergency medicine by the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada; (I-R)

C. A level II stroke center shall have a medical director of the emergency department who shall be a board-certified or board-admissible physician; (II-R)

D. A level III and IV stroke center shall have a medical director of the emergency department who is recommended to be a board-certified or board-admissible physician; (III-R, IV-R)

E. There shall be an emergency department physician credentialed for stroke care by the stroke center covering the emergency department twenty-four (24) hours a day, seven (7) days a week; (I-R/II-R, II-R/II-R, III-R/II-R, IV-R/II-R)

F. The emergency department physician who provides coverage shall be current in continuing medical education in the area of cerebrovascular disease; (I-R/II-R, II-R, III-R, IV-R)

G. There shall be a written policy defining the relationship of the emergency department physicians to other physician members of the stroke team; (I-R, II-R, III-R, IV-R)

H. Registered nurses in the emergency department shall be current in continuing education requirements as set forth in section (4) of this rule; (I-R/II-R, II-R, III-R, IV-R)

I. All registered nurses assigned to the emergency department shall be determined to be credentialed in the care of the stroke patient by the stroke center within one (1) year of assignment and remain current in continuing education requirements as set forth in section (4) of this rule; and (I-R, II-R, III-R, IV-R)

J. The emergency department in stroke centers shall have written care protocols for identification, triage, and treatment of acute stroke patients that are available to emergency department personnel, reviewed annually, and

revised as needed. (I-R, II-R, III-R, IV-R)

2. Nursing documentation for the stroke patient shall be on a stroke flow sheet approved by the stroke medical director and the stroke program coordinator/manager. (I-R, II-R, III-R, IV-R)

3. The emergency department shall have at least the following equipment for resuscitation and life support available to the unit:

A. Airway control and ventilation equipment including:

(I) Laryngoscopes; (I-R, II-R, III-R, IV-R)

(II) Endotracheal tubes; (I-R, II-R, III-R, IV-R)

(III) Bag-mask resuscitator; (I-R, II-R, III-R, IV-R)

(IV) Sources of oxygen; and (I-R, II-R, III-R, IV-R)

(V) Mechanical ventilator; (I-R, II-R, III-R)

B. Suction devices; (I-R, II-R, III-R, IV-R)

C. Electrocardiograph (ECG), cardiac monitor, and defibrillator; (I-R, II-R, III-R, IV-R)

D. Central line insertion equipment; (I-R, II-R, III-R)

E. All standard intravenous fluids and administration devices including intravenous catheters and intraosseous devices; (I-R, II-R, III-R, IV-R)

F. Drugs and supplies necessary for emergency care; (I-R, II-R, III-R, IV-R)

G. Two- (2-) way communication link with emergency medical service (EMS) vehicles; (I-R, II-R, III-R, IV-R)

H. End-tidal carbon dioxide monitor; and (I-R, II-R, III-R, IV-R)

I. Temperature control devices for patient and resuscitation fluids. (I-R, II-R, III-R, IV-R)

4. The stroke center emergency department shall maintain equipment following the hospital's preventive maintenance schedule and document when this equipment is checked. (I-R, II-R, III-R, IV-R)

(4) Continuing Medical Education (CME) and Continuing Education Standards for Stroke Center Designation.

(A) The stroke center shall ensure that staff providing services to stroke patients receives required continuing medical education and continuing education and document this continuing medical education and continuing education for each staff member. The department shall allow up to one (1) year from the date of the hospital's initial stroke center designation for stroke center staff members to complete all of the required continuing medical education and continuing education if the stroke center staff complete and document that at least half of the required continuing medical education and/or continuing education hours have been completed for each stroke center staff member at the time of on-site initial application review. The stroke center shall submit documentation to the department within one (1) year of the initial designation date that all continuing medical education and continuing education requirements for stroke center staff members have been met in order to maintain the stroke center's designation. (I-R, II-R, III-R, IV-R)

(B) The stroke call roster members shall complete the following continuing education requirements:

1. Level I core team members of the stroke call roster shall complete a minimum of *ten (10) eight (8)* hours of continuing education in cerebrovascular disease every year, and it is recommended that a portion of those hours shall be on stroke care. All other members of the stroke call roster in level I stroke centers shall complete a minimum average of *ten (10) eight (8)* hours of continuing education in cerebrovascular disease every year, **except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency**

**department.** This continuing education shall be reviewed for appropriateness to the practitioner's level of responsibility by the stroke medical director; **and** (I-R)

2. Level II core team members of the stroke call roster shall complete a minimum of eight (8) hours of continuing education in cerebrovascular disease every year, and it is recommended that a portion of those hours be in stroke care. *[All other members of the stroke call roster in level II stroke centers shall complete a minimum average of eight (8) hours of continuing education in cerebrovascular disease every year. This continuing education shall be reviewed for appropriateness to the practitioner's level of responsibility by the stroke medical director; and]* (II-R)

*[3. Level III and IV stroke call roster members shall complete a minimum average of eight (8) hours of continuing education in cerebrovascular disease every two (2) years. This continuing education shall be reviewed for appropriateness to the practitioner's level of responsibility by the stroke medical director. (III-R, IV-R)]*

(C) The stroke medical director shall complete the following continuing medical education requirements:

1. Level I **and** level II stroke medical directors shall complete a minimum of *[twelve (12)] eight (8)* hours of continuing medical education every year in the area of cerebrovascular disease; **and** (I-R, II-R)

2. Level III stroke medical directors shall complete a minimum of *[eight (8)] four (4)* hours of continuing medical education every year in the area of cerebrovascular disease; **and**. (III-R)

*[3. Level III and IV stroke medical directors shall complete a minimum of eight (8) hours of continuing medical education every two (2) years in the area of cerebrovascular disease. (III-R, IV-R)]*

(D) The stroke center's stroke program manager/coordinator shall complete the following continuing education requirements:

1. Level I program managers/coordinators shall:—

A. Complete a minimum of *[ten (10)] eight (8)* hours of continuing education every year in cerebrovascular disease. This continuing education shall be reviewed by the stroke medical director for appropriateness to the stroke program manager/coordinator's level of responsibility; **and** (I-R)

B. Attend one (1) national, regional, or state meeting every two (2) years focused on the area of cerebrovascular disease. If the national or regional meeting provides continuing education, then that continuing education may count toward the annual requirement; (I-R)

2. Level II program managers/coordinators shall—

A. Complete a minimum average of eight (8) hours of continuing education every year in cerebrovascular disease. This continuing education shall be reviewed for appropriateness by the stroke medical director to the stroke program manager/coordinator's level of responsibility; **and** (II-R)

B. Attend one (1) national, regional, or state meeting every three (3) years focused on the area of cerebrovascular disease. If the national, regional, or state meeting provides continuing education, then that continuing education may count toward the annual requirement; **and** (II-R)

3. Level III *[and IV]* center program managers/coordinators shall complete a minimum average of *[eight (8)] four (4)* hours of continuing education in cerebrovascular disease every *[two (2)] year[s]*. This continuing education shall be reviewed by the stroke medical director for appropriateness to the stroke program manager/coordinator's level of responsibility. (III-R, IV-R)]

(E) Emergency department personnel in stroke centers shall complete the following continuing education requirements:

1. Emergency department physicians in stroke centers shall complete—

A. Level I *[and II]* emergency department physicians providing stroke coverage shall complete a minimum *[average] of [four (4)] two (2)* hours of continuing medical education in cerebrovascular disease every year, **except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department; [or] (I-R, II-R)]**

*[B. Level III and IV emergency department physicians providing stroke coverage shall complete a minimum average of six (6) hours of continuing medical education in cerebrovascular disease every two (2) years; and (III-R, IV-R)]*

2. Registered nurses assigned to the emergency departments in stroke centers shall complete—

A. Level I *[and II]* registered nurses shall complete a minimum of *[four (4)] two (2)* hours of cerebrovascular disease continuing education every year; **and** (I-R, II-R)]

*[B. Level III and IV registered nurses shall complete a minimum of six (6) hours of cerebrovascular disease continuing education every two (2) years; and (III-R, IV-R)]*

*[C.]B.* Registered nurses shall maintain core competencies in the care of the stroke patient annually as determined by the stroke center. Training to maintain these competencies may count toward continuing education requirements. (I-R, II-R, III-R, IV-R)

(F) Registered nurses assigned to the intensive care unit in the stroke centers who care for stroke patients shall complete the following continuing education requirements:

1. Level I intensive care unit registered nurses shall complete a minimum of *[ten (10)] eight (8)* hours of cerebrovascular related continuing education every year; **and** (I-R)

*[2. Level II intensive care unit registered nurses shall complete a minimum of eight (8) hours of cerebrovascular related continuing education every year; and (II-R)]*

*[3.]2.* The stroke medical director shall review the continuing education for appropriateness to the practitioner's level of responsibility. (I-R, II-R)]

(G) Stroke unit registered nurses in the stroke centers shall complete the following continuing education requirements:

1. All level I stroke unit registered nurses shall complete a minimum of *[ten (10)] eight (8)* hours of cerebrovascular disease continuing education every year; **and** (I-R)

*[2. All level II stroke unit registered nurses shall complete a minimum of eight (8) hours of cerebrovascular disease continuing education every year; (II-R)]*

*3. All level III stroke centers caring for stroke patients under an established plan for admitting and caring for stroke patients under a supervised relationship with a physician affiliated with a level I or II stroke center shall require registered nurses in the stroke unit complete a minimum of eight (8) hours of cerebrovascular disease continuing education every two (2) years; and (III-R)]*

*[4.]2.* The stroke medical director shall review the continuing education for appropriateness to the practitioner's level of responsibility. (I-R, II-R, III-R)]

**AUTHORITY:** sections 192.006 **and** 190.185, RSMo [2000] 2016, and section[s] 190.185 **and**] 190.241, RSMo Supp. [2012] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars

(\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at [Nicole.Gamm@health.mo.gov](mailto:Nicole.Gamm@health.mo.gov) or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

#### **PROPOSED AMENDMENT**

**19 CSR 30-40.740 Definitions and Abbreviations Relating to ST-Segment Elevation Myocardial Infarction (STEMI) Centers.** The department is amending section (1).

*PURPOSE:* This amendment adds virtual reviews to the definitions for STEMI centers.

(1) For the purposes of 19 CSR 30-40.750 and 19 CSR 30-40.760 the following terms shall mean[;]–

(III) Thrombolytics—drugs, including recombinant tissue plasminogen activator, used to dissolve clots blocking flow in a blood vessel. These thrombolytic drugs are used in the treatment of acute ischemic stroke and acute myocardial infarction; [and]

(III) Transfer agreement—a document which sets forth the rights and responsibilities of two (2) hospitals regarding the inter-hospital transfer of patients[;]; and

(KKK) Virtual review—a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.

*AUTHORITY:* sections 192.006 and 190.185, RSMo [2000] 2016, and section[s] 190.185 and] 190.241, RSMo Supp. [2012] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at [Nicole.Gamm@health.mo.gov](mailto:Nicole.Gamm@health.mo.gov) or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

#### **PROPOSED AMENDMENT**

**19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review.** The department is amending sections (2) and (3), renumbering as necessary, and amending the application for STEMI center designation form.

*PURPOSE:* This amendment adds virtual review requirements, clarifies honorarium and payment requirements for virtual reviews, updates language to be consistent with House Bill 2331 which made changes to sections 190.241 and 190.245, RSMo, effective August 28, 2022, adds Comprehensive Heart Attack Center by the Joint Commission as a type of certification or verification that hospitals may have in order for the department to designate hospitals as level II STEMI centers, adds a requirement that hospitals must provide the department with required medical records and quality improvement documentation or be revoked, allows hospitals to continue to be designated as long as the hospital has submitted an application and the department has not yet been able to conduct a review before expiration, changes the requirements for hospitals participating in local and regional emergency medical services system, removes the data submission requirement for hospitals verified or certified by department-approved national certifying bodies, and updates what the hospitals have to submit to the department to confirm verification or certification with national certifying bodies and when to submit changes of this verification or certification. This amendment also makes changes to the application for STEMI center designation form included herein in subsection (3)(A) by adding Comprehensive Heart Attack Center, changing the certification section to reflect the new requirements for notification of changes and participation in local and regional emergency medical services systems, and removing the data submission requirement.

(2) Hospitals requesting to be reviewed and designated as a STEMI center by the department shall meet the following requirements:

(D) The department may conduct an on-site review, a virtual review, or a combination thereof on the hospitals/STEMI centers. For announced reviews that are scheduled with the hospitals/STEMI centers, the department will make the hospitals/STEMI centers aware at least thirty (30) days prior to the scheduled review whether the department intends that the review will be conducted on-site and/or virtually. Due to unforeseen circumstances, the department may need to change whether the review is conducted on-site and/or virtually less than thirty (30) days before the announced review. The department will contact the hospitals/STEMI centers to make the hospitals/STEMI centers aware of any changes about how the review will be conducted, either on-site and/or virtually, prior to the date of the announced review. The different types of [site] reviews to be conducted on hospitals/STEMI centers seeking STEMI center designation by the department include[;]–

1. An initial review shall occur on a hospital applying to be initially designated as a STEMI center. An initial review shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **This review may occur on-site and/or virtually;**

2. A validation review shall occur on a designated STEMI center applying for renewal of its designation as a STEMI center. Validation reviews shall occur no less than every three (3) years. A validation review shall include interviews with designated STEMI center staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the rules of this chapter. **This review may occur on-site and/or virtually;** and

3. A focus review shall occur on a designated STEMI center in which an initial or validation review was conducted and substantial deficiency(ies) were cited. A review of the physical plant will not be necessary unless a deficiency(ies) was cited in the physical plant in the preceding validation review. The focus review team shall be comprised of a representative from the department and may include a qualified contractor(s) with the required expertise to evaluate corrections in areas where deficiencies were cited. **This review may occur on-site and/or virtually;**

(E) STEMI center designation shall be valid for a period of three (3) years from the date the STEMI center/hospital is designated. **Expiration of the designation shall occur unless the STEMI center applies for validation review within this three- (3-) year period and the department is unable to conduct a review before the designation expires.**

1. STEMI center designation shall be site specific and non-transferable when a STEMI center changes location.

2. Once designated as a STEMI center, a STEMI center may voluntarily surrender the designation at any time without giving cause, by contacting the department in writing. In these cases, the application and review process shall be completed again before the designation may be reinstated;

(H) Hospitals/STEMI centers shall be responsible for paying expenses related to the costs of the qualified contractors to review their respective hospitals/STEMI center during initial, validation, and focus reviews. The department shall be responsible for paying the expenses of its representative. Costs of the review to be paid by the hospital/STEMI center include:]—

1. An honorarium shall be paid to each qualified contractor of the review team **whether the review occurs on-site or virtually.** Qualified contractors of the review team for level I and II STEMI center reviews shall be paid *[six hundred dollars (\$600) for the day of travel per reviewer and eight hundred fifty dollars (\$850) for the day of the review]* **one thousand four hundred fifty dollars (\$1,450)** per reviewer. Qualified contractors of the review team for level III and IV STEMI center reviews shall be paid *[five hundred dollars (\$500) for the day of travel per reviewer and five hundred dollars (\$500) for the day of the review]* **one thousand dollars (\$1,000)** per reviewer. This honorarium shall be paid to each qualified contractor of the review team at the time the site survey begins **if on-site or prior to the review beginning if the review is conducted virtually;**

2. Airfare shall be paid for each qualified contractor of the review team, if applicable;

3. Lodging shall be paid for each qualified contractor of the review team, **unless the review is conducted virtually.** The hospital/STEMI center shall secure the appropriate number of hotel rooms for the qualified contractors and pay the hotel directly; and

4. Incidental expenses, if applicable, for each qualified contractor of the review team shall not exceed two hundred fifty dollars (\$250) and may include the following:

- A. Airport parking;
- B. Checking bag charges;
- C. Meals during the review; and
- D. Mileage to and from the review if no airfare was charged by the reviewer. **If the reviewer solely participat-**

**ed virtually in the review and did not travel by vehicle to the review, then no mileage shall be paid.** Mileage shall be paid at the federal mileage rate for business miles as set by the Internal Revenue Service (IRS). Federal mileage rates can be found at the website [www.irs.gov](http://www.irs.gov);

**(I) Hospitals/STEMI centers being reviewed through a virtual survey shall do the following:**

1. Provide a videoconferencing platform to be used for the hospital/STEMI center virtual review;

2. Provide a live tour of the hospital;

3. Ensure the videoconferencing platform used during the review is compliant with state and federal laws for protected health information;

4. Assign an on-site visit coordinator for the review. The on-site visit coordinator role cannot be fulfilled by the STEMI program manager. This on-site visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:

A. Scheduling the videoconferencing meetings;

B. Sending out calendar invitations;

C. Providing electronic medical record (EMR) access to designated individuals;

D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and

E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors, and the department;

5. Assign one (1) staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the STEMI program manager, the STEMI program medical director, the STEMI program registrar, or the on-site visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR;

6. Provide the department with requested patient care report information for the review no later than thirty (30) days prior to the virtual review;

7. Provide the department with requested medical records, PIPS documentation, registry report, and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;

8. Schedule a pre-review call with the qualified contractors, the department, the STEMI program medical director, the STEMI program manager, the staff navigators and the on-site visit coordinator approximately one (1) week prior to the virtual review;

9. Test the functionality of the videoconferencing platform for the live tour of the hospital prior to the pre-review call; and

10. Provide a list of attendees for the review meeting and their roles to the review team and the department prior to the virtual review;

**(J) The department may conduct an on-site review of the hospital prior to the virtual review process to ensure that the hospital meets the requirements for STEMI center designation;**

**[(I)](K)** Upon completion of a review, the qualified contractors from the review team shall submit a report of their findings to the department. This report shall state whether the specific standards for STEMI center designation have or have not been met and if not met, in what way they were not met. This report shall detail the hospital/STEMI center's strengths, weaknesses, deficiencies, and recommendations for areas of improvement. This report shall also include findings from patient chart audits

and a narrative summary of the following areas: prehospital, hospital, STEMI service, emergency department, operating room, angiography suites, recovery room, clinical lab, intensive care unit, rehabilitation, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department shall have the final authority to determine compliance with the rules of this chapter;

**[(J)](L)** The department shall return a copy of the report to the chief executive officer, the STEMI medical director, and the STEMI program manager/coordinator of the hospital/STEMI center reviewed. Included within the report shall be notification indicating whether the hospital/STEMI center has met the criteria for STEMI center designation or has failed to meet the criteria for STEMI center designation as requested. Also, if a focus review of the STEMI center is required, the time frame for this focus review will be shared with the chief executive officer, the STEMI medical director, and the STEMI program manager/coordinator of the STEMI center reviewed;

**[(K)](M)** When the hospital/STEMI center is found to have deficiencies, the hospital/STEMI center shall submit a plan of correction to the department. The plan of correction shall include identified deficiencies, actions to be taken to correct deficiencies, time frame in which the deficiencies are expected to be resolved, and the person responsible for the actions to resolve the deficiencies. A plan of correction form shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings and designation. If a focus review is required, the STEMI center shall be allowed a minimum period of six (6) months to correct deficiencies;

**[(L)](N)** No hospital shall hold itself out as a STEMI center designated by the department until given written approval by the department. The department shall give written approval to the hospitals to begin holding themselves out as designated STEMI centers by the department after all initial STEMI reviews have been completed for those hospitals which applied for STEMI review and designation with the department during the first round of applications and the time for plans of corrections have expired;

**[(M)](O)** A STEMI center shall make the department aware in writing within thirty (30) days if there are any changes in the STEMI center's name, address, contact information, chief executive officer, STEMI medical director, or STEMI program manager/coordinator;

**(P) Failure of a hospital/STEMI center to provide all medical records and quality improvement documentation necessary for the department to conduct a STEMI review in order to determine if the requirements of 19 CSR 30-40.760 have been met shall result in the revocation of the hospital/STEMI center's designation as a STEMI center;**

**[(N)](Q)** Any person aggrieved by an action of the department affecting the STEMI center designation pursuant to Chapter 190, RSMo, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination by the Administrative Hearing Commission under Chapter 621, RSMo. It shall not be a condition to such determination that the person aggrieved seek reconsideration, a rehearing, or exhaust any other procedure within the department; and

**[(O)](R)** The department may deny, place on probation, suspend, or revoke such designation in any case in which it has **[reasonable cause to believe] determined** that there has been a substantial failure to comply with the provisions of Chapter 190, RSMo, or any rules or regulations promulgated pursuant to this chapter. If the department has **[reasonable cause to believe] determined** that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site reviews of the hospital to verify

compliance. If a STEMI center fails two (2) consecutive on-site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245, RSMo, or rules adopted by the department pursuant to sections 190.001 to 190.245, RSMo, its center designation shall be revoked.

(3) Hospitals seeking STEMI center designation by the department based on their current certification **or verification** as a STEMI center by the Joint Commission, American Heart Association, or American College of Cardiology shall meet the following requirements:

(A) An application for STEMI center designation by the department for hospitals that have been certified **or verified** as a STEMI/chest pain center by the Joint Commission, American Heart Association, or American College of Cardiology shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to make a determination of eligibility for review and designation in accordance with the rules of this chapter. The application for STEMI certified hospital designation form, included herein, is available at the Health Standards and Licensure (HSL) office, or online at the department's website at [www.health.mo.gov](http://www.health.mo.gov), or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for STEMI center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation or expiration of the current designation;

(B) Both sections A and B of the application for STEMI certified hospital designation form, included herein, shall be complete before the department designates a hospital/STEMI center. The department shall notify the hospital/STEMI center of any apparent omissions or errors in the completion of the application for STEMI certified hospital designation form. Upon receipt of a completed and approved application, the department shall designate such hospital as follows:

1. The department shall designate a hospital as a level I STEMI center if such hospital has been certified as a comprehensive cardiac center by the Joint Commission;

2. The department shall designate a hospital as a level II STEMI center if such hospital has been certified as any of the following:

A. Mission Lifeline Percutaneous Coronary Intervention (PCI)/STEMI receiving center by the American Heart Association;

B. Chest pain center with PCI center by the American College of Cardiology;

C. Chest pain with PCI and resuscitation center by the American College of Cardiology; **[or]**

D. Primary Heart Attack Center by the Joint Commission; **or**

**E. Comprehensive Heart Attack Center by the Joint Commission;**

3. The department shall designate a hospital as a level III STEMI center if such hospital has been certified as any of the following:

A. Mission Lifeline non/PCI STEMI referral center by the American Heart Association;

B. Chest pain center by the Joint Commission;

C. Acute Heart Attack Ready Center by the Joint Commission;

D. Primary Acute Myocardial Infarction (AMI) center by the Joint Commission; **or**

E. Chest pain center by the American College of Cardiology;

(C) No hospital shall hold itself out as a STEMI center designated by the department until given written approval by the

department. The department shall give written approval to the hospitals to begin holding themselves out as designated STEMI centers by the department *[after all initial STEMI reviews have been completed for those hospitals which applied for STEMI review and designation with the department during the first round of applications and the time for plans of corrections have expired]*. This does not prohibit the hospitals from holding themselves out as certified STEMI/chest pain centers by the Joint Commission, the American Heart Association, or the American College of Cardiology;

*[(D) Annually from the date of designation by the department submit to the department proof of certification as a STEMI/chest pain center by the Joint Commission, the American Heart Association, or the American College of Cardiology and the names and contact information of the medical director of the STEMI/chest pain center and the program manager of the STEMI chest pain center;]*

*[(E)](D) Within thirty (30) days of any changes or receipt of a certificate or verification, the hospital shall submit to the department proof of certification as a STEMI/chest pain center by the Joint Commission, the American Heart Association, or the American College of Cardiology and the names and contact information of the medical director of the STEMI/chest pain center and the program manager of the STEMI/chest pain center. A certificate or verification as a STEMI center by the Joint Commission, the American Heart Association, or the American College of Cardiology shall accompany the application for STEMI certified hospital designation form. A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is certified or verified as a STEMI center by the Joint Commission, the American Heart Association, or the American College of Cardiology for which the hospital used to receive its corresponding designation by the department as a STEMI center, whether because the hospital voluntarily surrendered this certificate or verification, or because the hospital's certificate or verification was suspended or revoked by the Joint Commission, the American Heart Association, or the American College of Cardiology or expired;*

*[(F) Submit to the department a copy of the certifying organization's final STEMI/chest pain center certification survey results within thirty (30) days of receiving such results;*

*(G) Submit to the department a completed application for STEMI certified hospital designation form every three (3) years;*

*(H) Participate in the emergency medical services regional system of STEMI care in its respective emergency medical services region as defined in 19 CSR 30-40.302;*

*(I) Any hospital designated as a level III STEMI center that is certified by the Joint Commission, the American Heart Association, or the American College of Cardiology shall have a formal agreement with a level I or level II STEMI center designated by the department for physician consultative services for evaluation of STEMI patients;]*

*[(J)](E) Participate in local and regional emergency medical services systems [by reviewing and sharing outcome data and] for purposes of providing training [and], sharing clinical educational resources, and collaborating on improving patient outcomes;*

*[(K) Submit data to meet the data submission requirements in section 190.241, RSMo, and 19 CSR 30-40.760;]*

*[(L)](F) The designation of a hospital as a STEMI center pursuant to section (3) shall continue if such hospital retains certification as a STEMI center by the Joint Commission, the American Heart Association, or the American College of Cardiology; and*

*[(M)](G) The department may remove a hospital's designation as a STEMI center if requested by the hospital or the department determines that the Joint Commission, the Ameri-*

can Heart Association, or **the** American College of Cardiology certification **or verification** has been suspended or revoked. The department may also remove a hospital's designation as a STEMI center if the department determines the hospital's certification **or verification** with the Joint Commission, the American Heart Association, or **the** American College of Cardiology has expired. Any decision made by the department to withdraw the designation of a STEMI center that is based on the revocation or suspension of a certification **or verification** by the Joint Commission, the American Heart Association, or the American College of Cardiology shall not be subject to judicial review.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION OF HEALTH STANDARDS AND LICENSURE

**APPLICATION FOR ST-ELEVATION MYOCARDIAL INFARCTION (STEMI)  
CERTIFIED HOSPITAL DESIGNATION**

SECTION A		
In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a STEMI center. Please complete all information.		ORGANIZATION'S STEMI IDENTIFICATION NUMBER
CURRENT STEMI CERTIFICATION ORGANIZATION AND LEVEL		
LEVEL I	LEVEL II	LEVEL III
<input type="checkbox"/> Joint Commission, Comprehensive Cardiac Center	<input type="checkbox"/> American Heart Association, Mission Lifeline Percutaneous Coronary Intervention (PCI)/STEMI Receiving Center <input type="checkbox"/> American College of Cardiology, Chest Pain with PCI Center <input type="checkbox"/> American College of Cardiology, Chest Pain with PCI and Resuscitation Center <input type="checkbox"/> Joint Commission, Primary Heart Attack Center <input type="checkbox"/> Joint Commission, Comprehensive Heart Attack Center	<input type="checkbox"/> American Heart Association, Mission Lifeline Non/PCI STEMI Referral Center <input type="checkbox"/> Joint Commission, Chest Pain Center <input type="checkbox"/> Joint Commission, Primary Acute Myocardial Infarction (AMI) Center <input type="checkbox"/> American College of Cardiology, Chest Pain Center <input type="checkbox"/> Joint Commission, Acute Heart Attack Ready Center
HOSPITAL INFORMATION		
NAME OF HOSPITAL (NAME TO APPEAR ON DESIGNATION CERTIFICATE)		TELEPHONE NUMBER
ADDRESS (STREET AND NUMBER)	CITY	ZIP CODE
PROFESSIONAL INFORMATION		
CHIEF EXECUTIVE OFFICER		CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES
STEMI MEDICAL DIRECTOR (NAME, EMAIL, AND CONTACT PHONE NUMBER)		STEMI PROGRAM MANAGER (NAME, EMAIL, AND CONTACT PHONE NUMBER)
SECTION B		
The following should be submitted to the department as indicated:		
<input type="checkbox"/> Proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology with the expiration date of the certification.		
CERTIFICATION		
We, the undersigned, hereby certify that:		
<p>A. Within thirty (30) days of any changes or receipt of a certificate or verification, we will submit to the department proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology.</p> <p>B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of the STEMI center.</p> <p>C. Within thirty (30) days that our hospital is no longer certified or verified with the Joint Commission, the American Heart Association or the American College of Cardiology, whether because we voluntarily surrendered our certification or verification or because our certification or verification has been suspended or revoked by the Joint Commission, the American Heart Association or American College of Cardiology or expired, we will report this change in writing to the department.</p> <p>D. We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes.</p> <p>E. We understand that our designation as a STEMI center by the department shall continue only if our hospital remains certified as a STEMI center by the Joint Commission, the American Heart Association or the American College of Cardiology.</p>		
DATE OF APPLICATION		
SIGNED (CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP)		
SIGNED (HOSPITAL CHIEF EXECUTIVE OFFICER)		
SIGNED (STEMI MEDICAL DIRECTOR)		
SIGNED (DIRECTOR OF EMERGENCY MEDICINE)		

*AUTHORITY:* sections 190.185 and 192.006, RSMo 2016, and section 190.241, RSMo Supp. [2019] 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.

*PUBLIC COST:* This proposed amendment will cost state agencies or political subdivisions two thousand five hundred dollars (\$2,500) during a three- (3-) year designation period.

*PRIVATE COST:* This proposed amendment will cost private entities eight thousand seven hundred fifty dollars (\$8,750) during a three- (3-) year designation period.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with NicoleGamm at [Nicole.Gamm@health.mo.gov](mailto:Nicole.Gamm@health.mo.gov) or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: Department of Health and Senior Services  
Division Title: Division of Regulation and Licensure  
Chapter Title: 19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review.**

<b>Rule Number and Title:</b>	19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
10 private hospitals/STEMI centers	\$2,500 during a 3 year designation period
<b>TOTAL COSTS =</b>	<b>\$2,500 during a 3 year designation period</b>

**III. WORKSHEET**

Ten (10) public hospitals/STEMI centers reviewed during a three (3) year designation period X \$250.00 = \$2,500 for public hospitals/STEMI centers reviewed during a three (3) year period.

**IV. ASSUMPTIONS**

There are currently forty-five (45) Level I-IV STEMI centers designated with the department. Ten (10) of the STEMI centers are public hospitals/STEMI centers which will be reviewed during a three (3) year designation period.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.750 will cost hospitals/STEMI centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Department of Health and Senior Services**  
**Division Title: Division of Regulation and Licensure**  
**Chapter Title: 19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review.**

<b>Rule Number and Title:</b>	19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review
<b>Type of Rulemaking:</b>	Proposed Amendment

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
35 private hospitals/STEMI centers for virtual review costs	\$8,750 during a 3 year designation period
<b>TOTAL COSTS =</b>	<b>\$8,750 during a 3 year designation period</b>

**III. WORKSHEET**

Thirty-five (35) private hospitals/STEMI centers reviewed during a three (3) year designation period X \$250.00 = \$8,750 for private hospitals/STEMI centers reviewed during a three (3) year period.

**IV. ASSUMPTIONS**

There are currently forty-five (45) Level I-IV STEMI centers designated with the department. Thirty-five (35) of the STEMI centers are private hospitals/STEMI centers which will be reviewed during a three (3) year designation period.

All hospitals have internet capability, programs for the use of virtual meetings and the use of a secure means to send documents which contain information subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The department estimates that costs associated with the additional virtual survey requirements in 19 CSR 30-40.750 will cost hospitals/STEMI centers approximately \$250 based on the use of the computer programs to send this information and to utilize for virtual meetings and during the review (including the live tour).

**TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

**Division 30 – Division of Regulation and Licensure  
Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations**

**PROPOSED AMENDMENT**

**19 CSR 30-40.760 Standards for ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation.** The department is amending sections (1), (3), and (4) and renumbering as necessary.

*PURPOSE: This amendment changes continuing education hours to be consistent with required continuing education requirements by national designating or verifying bodies of STEMI centers, removes continuing medical education requirements for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine and who are practicing in the emergency department of a STEMI center, removes requirements relating to the operation or construction of a helipad at STEMI centers, and adds an option for STEMI centers to enter STEMI data into a national data registry or databank that will allow the STEMI center to perform its performance improvement, and patient safety program requirements.*

(1) General Standards for STEMI Center Designation.

(G) The STEMI center shall appoint a physician to serve as the STEMI medical director with appropriate qualifications, experience, and training. A STEMI medical director shall be appointed at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. Level I and II STEMI center medical directors shall be cardiologists or interventional cardiologists. It is recommended that the cardiologist or interventional cardiologist be board-certified or board-admissible in interventional cardiology or cardiology. (I-R, II-R)

2. Level III and IV STEMI center medical directors shall be physicians. A board-certified or board-admissible physician is recommended. (III-R, IV-R)

3. The STEMI center shall have a job description and organization chart depicting the relationship between the STEMI medical director and other services. (I-R, II-R, III-R, IV-R)

4. Level I and II STEMI medical directors are recommended to be members of the catheterization lab team call roster. (I-R, II-R)

5. The STEMI medical director shall meet the continuing medical education (CME) requirements as described in section (4) of this rule. (I-R, II-R, III-R, IV-R)

6. The STEMI medical director shall be responsible for oversight of the education and training of the medical and clinical staff in STEMI care. This includes a review of the appropriateness of the education and training for the practitioner's level of responsibility. (I-R, II-R, III-R, IV-R)

7. Level I STEMI medical directors shall participate in the STEMI center's research and publication projects. (I-R)

(H) The STEMI center shall have a STEMI program coordinator/manager who is a registered nurse, other clinical staff, or qualified individual. The STEMI center shall have a STEMI program coordinator/manager at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. The STEMI center shall have a job description and organization chart depicting the relationship between the STEMI program coordinator/manager and other services. (I-R, II-R, III-R, IV-R)

2. The STEMI coordinator/manager shall meet continuing education requirements as described in section (4) of this rule. (I-R, II-R, III-R, IV-R)

3. The STEMI program coordinator/manager shall participate in the formal STEMI center performance

improvement and patient safety program. (I-R, II-R, III-R, IV-R)

[(R) Level I, II, and III STEMI centers shall have a lighted designated helicopter landing area at the STEMI center to accommodate incoming medical helicopters. (I-R, II-R, III-R)]

1. The landing area shall serve solely as the receiving and take-off area for medical helicopters and shall be cordoned off at all times from the general public to assure its continual availability and safe operation. (I-R, II-R, III-R)

2. The landing area shall be on the hospital premises no more than three (3) minutes from the emergency room. (I-R, II-R, III-R)

(S) Level IV STEMI centers shall have a lighted designated helicopter landing area that meets the following requirements:

1. Accommodates incoming medical helicopters; (IV-R)

2. Serves as the receiving and take-off area for medical helicopters; (IV-R)

3. Cordoned off from the general public when in use; (IV-R)

4. Managed to assure its continual availability and safe operation; and (IV-R)

5. It is recommended the landing area shall be no more than three (3) minutes from the emergency department. (IV-R)]

(R) The STEMI center shall have a helicopter landing area. (I-R, II-R, III-R, IV-R)

[(T)](S) STEMI centers shall enter data into [the Missouri] a STEMI registry as follows:

1. [All] STEMI centers shall submit data into the department's Missouri STEMI registry on each STEMI patient who is admitted to the STEMI center, transferred out of the STEMI center, or dies as a result of the STEMI (independent of hospital admission or hospital transfer status). The data required to be submitted into the Missouri STEMI registry by the STEMI centers is listed and explained in the document entitled "Time Critical Diagnosis ST-Segment Elevation Myocardial Infarction (STEMI) Center Registry Data Elements," dated March 1, 2012, which is incorporated by reference in this rule and is available at the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570 or on the department's website at [www.health.mo.gov](http://www.health.mo.gov). This rule does not incorporate any subsequent amendments or additions; (I-R, II-R, III-R, IV-R).

[2.] The data [required in paragraph (1)(T)1. above] shall be submitted electronically into the Missouri STEMI registry via the department's website at [www.health.mo.gov](http://www.health.mo.gov); or (I-R, II-R, III-R, IV-R)

2. STEMI centers shall submit data into a national data registry or data bank capable of being used by the STEMI center to perform its ongoing performance improvement and patient safety program requirements for its STEMI patients. STEMI centers shall submit data for each data element included in the national data registry or data bank's data system; (I-R, II-R, III-R, IV-R)

3. This data required in paragraphs (1)(T)1. and 2. above shall be submitted electronically into the [Missouri] STEMI registry on at least a quarterly basis for that calendar year. STEMI centers have ninety (90) days after the quarter ends to submit the data electronically into the [Missouri] STEMI registry; (I-R, II-R, III-R, IV-R)

4. The data submitted by the STEMI centers shall be complete and current; and (I-R, II-R, III-R, IV-R)

5. The data submitted by the STEMI centers shall be managed in compliance with the confidentiality requirements and procedures contained in section 192.067, RSMo. (I-R, II-R, III-R, IV-R)

[(U)](T) A STEMI center shall maintain a diversion protocol for the STEMI center that is designed to allow best resource management within a given area. The STEMI center shall create criteria for diversion in this diversion protocol and shall detail a performance improvement and patient safety process in the diversion protocol to review and validate the

criteria for diversion created by the STEMI center. The STEMI center shall also collect, document, and maintain diversion information that includes at least the date, length of time, and reason for diversion. This diversion information shall be readily retrievable by the STEMI center during a review by the department and shall be kept by the STEMI center for a period of five (5) years. (I-R, II-R, III-R, IV-R)

(3) Standards for Hospital Resources and Capabilities for STEMI Center Designation.

(A) The STEMI center shall meet emergency department standards listed below.

1. The emergency department staffing shall meet the following requirements:

A. The emergency department in the STEMI center shall provide immediate and appropriate care of the STEMI patient; (I-R, II-R, III-R, IV-R)

B. A level I STEMI center shall have a medical director of the emergency department who shall be a board-certified or board-admissible physician in emergency medicine by the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada; (I-R)

C. A level II STEMI center shall have a medical director of the emergency department who shall be a board-certified or board-admissible physician; (II-R)

D. A level III and IV STEMI center shall have a medical director of the emergency department who is recommended to be a board-certified or board-admissible physician; (III-R, IV-R)

E. There shall be an emergency department physician credentialed for STEMI care covering the emergency department twenty-four (24) hours a day, seven (7) days a week; (I-R/IH, II-R/IH, III-R/IH, IV-R/IA)

F. The emergency department physician who provides coverage shall be current in continuing medical education (CME) in the area of cardiovascular disease as set forth in section (4) of this rule; (I-R[, II-R, III-R, IV-R])

G. There shall be a written policy defining the organizational relationship of the emergency department physicians to other physician members of the STEMI team; (I-R, II-R, III-R, IV-R)

H. Registered nurses in the emergency department shall be current in continuing education requirements as set forth in section (4) of this rule; (I-R [, II-R, III-R, IV-R])

I. At a minimum, all registered nurses assigned to the emergency department shall be determined to be credentialed in the care of the STEMI patient by the STEMI center within one (1) year of assignment in the emergency department, and these registered nurses shall remain current in continuing education requirements as set forth in section (4) of this rule; and (I-R, II-R, III-R, IV-R)

J. The emergency department in STEMI centers shall have written care protocols for identification, triage, and treatment of acute STEMI patients that are available to emergency department personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R, IV-R)

2. Nursing documentation for the STEMI patient shall be on a STEMI flow sheet approved by the STEMI medical director and the STEMI program manager/coordinator. (I-R, II-R, III-R, IV-R)

3. The emergency department shall have at least the following equipment for resuscitation and life support available to the unit:

A. Airway control and ventilation equipment including:

(I) Laryngoscopes; (I-R, II-R, III-R, IV-R)

(II) Endotracheal tubes; (I-R, II-R, III-R, IV-R)

(III) Bag-mask resuscitator; (I-R, II-R, III-R, IV-R)

(IV) Sources of oxygen; and (I-R, II-R, III-R, IV-R)

(V) Mechanical ventilator; (I-R, II-R, III-R)

B. Suction devices; (I-R, II-R, III-R, IV-R)

C. Electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R, III-R, IV-R)

D. Central line insertion equipment; (I-R, II-R, III-R)

E. All standard intravenous fluids and administration devices including intravenous catheters and intraosseous devices; (I-R, II-R, III-R, IV-R)

F. Drugs and supplies necessary for STEMI emergency care; (I-R, II-R, III-R, IV-R)

G. Two- (2-) way communication link with emergency medical service (EMS) vehicles; (I-R, II-R, III-R, IV-R)

H. Equipment necessary to communicate with emergency medical services regarding pre-hospital ECG STEMI findings; (I-R, II-R, III-R, IV-R)

I. End-tidal carbon dioxide monitor; (I-R, II-R, III-R, IV-R)

J. Temperature control devices for patient and resuscitation fluids; (I-R, II-R, III-R, IV-R)

K. External pacemaker; and (I-R, II-R, III-R, IV-R)

L. Transvenous pacemaker. (I-R/IA, II-R/IA, III-R/IA)

4. The STEMI center emergency department shall maintain all equipment according to the hospital preventive maintenance schedule and document when the equipment is checked. (I-R, II-R, III-R, IV-R)

(D) The STEMI center shall have an intermediate care unit (e.g., step down unit). (I-R, II-R, III-R)

1. The STEMI center shall have a designated medical director for the STEMI center intermediate care unit who has access to a physician knowledgeable in STEMI care and who meets the STEMI call roster continuing medical education requirements as set forth in section (4) of this rule. (I-R, II-R, III-R)

2. The STEMI center intermediate care unit shall have a physician on duty or available twenty-four (24) hours a day, seven (7) days a week who is not the emergency department physician. This physician shall have access to a physician on the STEMI call roster. (I-R/IA, II-R/IA, III-R/IA)

3. The STEMI center intermediate care unit shall have registered nurses and other essential personnel on duty twenty-four (24) hours a day, seven (7) days a week. (I-R, II-R, III-R)

4. The STEMI center intermediate care unit registered nurses shall remain current in continuing education requirements as set forth in section (4) of this rule. (I-R[, II-R, III-R])

5. The STEMI centers shall annually credential registered nurses that work in the intermediate care unit. (I-R, II-R, III-R)

6. The STEMI center intermediate care unit shall have written care protocols for identification and treatment of STEMI patients which are available to the cardiac unit personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R)

7. The STEMI center intermediate care unit shall have equipment to support the care and resuscitation of the STEMI patient that includes at least the following:

A. Airway control and ventilation equipment including:

(I) Laryngoscopes, endotracheal tubes of all sizes; (I-R, II-R, III-R)

(II) Bag-mask resuscitator and sources of oxygen; and (I-R, II-R, III-R)

(III) Suction devices; and (I-R, II-R, III-R)

B. Telemetry, electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R, III-R)

C. All standard intravenous fluids and administration devices and intravenous catheters; and (I-R, II-R, III-R)

D. Drugs and supplies necessary for emergency care. (I-R, II-R, III-R)

8. The STEMI center intermediate care unit shall maintain equipment according to the STEMI center's preventive maintenance schedule and document when the equipment is

checked. (I-R, II-R, III-R)

(4) Continuing Medical Education (CME) and Continuing Education Standards for STEMI Center Designation.

(A) The STEMI center shall ensure that staff providing services to STEMI patients receive continued medical education and continuing education as set forth in section (4) of this rule and document this education for each staff member. The department shall allow up to one (1) year from the date of the STEMI center's initial STEMI center designation for STEMI center staff members to complete all of the required continuing medical education and/or continuing education requirements if the STEMI center staff documents that at least half of the required continuing medical education and continuing education hours have been completed for each STEMI center staff at the time of the on-site initial application review. The STEMI center shall submit documentation to the department within one (1) year of the initial designation date that all continued medical education and continuing education requirements for STEMI center staff members have been met in order to maintain the STEMI center's designation. (I-R[, II-R, III-R, IV-R])

(B) The STEMI call roster members shall complete the following continuing education requirements:

1. Core team members of the STEMI call roster in level I *[and level II]* STEMI centers shall document a minimum of *[ten (10)] eight (8)* hours every year of continuing education in the area of acute coronary syndrome. All other members of the STEMI call roster shall document a minimum of *[ten (10)] eight (8)* hours every year of continuing education in the area of cardiovascular disease, **except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department.** This continuing education shall be reviewed by the STEMI center medical director for appropriateness to the practitioner's level of responsibility. *;* and *[I-R[, II-R]*

*[2. All members of the STEMI call roster in level III and level IV STEMI centers shall document a minimum of eight (8) hours every two (2) years of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed by the STEMI center medical director for appropriateness to the practitioner's level of responsibility. (III-R, IV-R)]*

(C) The STEMI center medical director shall complete the following continuing medical education requirements:

1. Level I *[and II]* STEMI medical directors shall document a minimum average of *[ten (10)] eight (8)* hours every year in the area of acute coronary syndrome *;* *[I-R[, II-R]*

*[2. The level III and IV STEMI medical directors that are board-certified or board-eligible shall document a minimum average of eight (8) hours every other year of continuing medical education in the area of cardiovascular disease; and (III-R, IV-R)]*

3. *The level III and IV STEMI medical directors who are not board-certified or board-eligible shall document:*

A. *A minimum average of ten (10) hours every two (2) years of continuing medical education in the area of cardiovascular disease with a focus on acute coronary syndrome; and (III-R, IV-R)*

B. *Attend one (1) national, regional, or state meeting every three (3) years in cardiovascular disease. Continuing medical education earned at these meetings can count toward the ten (10) continuing medical education hours required. (III-R, IV-R)]*

(D) The STEMI center's STEMI program manager/coordinator shall complete the following continuing education

requirements:

1. A level I STEMI program coordinator/manager shall complete and document the following:

A. A minimum average of *[ten (10)] eight (8)* hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the STEMI program manager's/coordinator's level of responsibility; and (I-R)

B. Attend one (1) national, regional, or state meeting every two (2) years focused on cardiovascular disease. If the national, regional, or state meeting provides continuing education, that continuing education may count towards the annual requirement *;* *[I-R]*

*[2. A level II STEMI program coordinator/manager shall complete and document the following:*

A. *A minimum average of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed by the STEMI center medical director for appropriateness to the STEMI program manager's/coordinator's level of responsibility; and (II-R)*

B. *Attend one (1) national, regional, or state meeting every three (3) years focused on cardiovascular disease. If the national, regional, or state meeting provides continuing education, that continuing education may count toward the annual requirement; and (II-R)*

3. *The level III and IV STEMI program coordinator/manager shall complete and document a minimum average of eight (8) hours every other year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the STEMI program manager's/coordinator's level of responsibility. (III-R, IV-R)]*

(E) STEMI center emergency department personnel shall complete the continuing education requirements for STEMI centers that are detailed below.

1. The emergency department physician(s) shall be current in cardiovascular continuing medical education. (I-R[, II-R, III-R, IV-R])

A. Emergency department physicians in level I *[and II]* STEMI centers shall complete and document a minimum average of *[four (4)] two (2)* hours every year of continuing medical education in the area of cardiovascular disease, **except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department.** (I-R[, II-R])

*[B. Emergency department physicians in level III and IV STEMI centers shall complete and document a minimum average of six (6) hours every two (2) years of continuing medical education in the area of cardiovascular disease. (III-R, IV-R)]*

2. Registered nurses assigned to the emergency department shall complete the following requirements:

A. Registered nurses assigned to the emergency department at level I *[and II]* STEMI centers shall complete and document a minimum of *[four (4)] two (2)* hours of continuing education every year in the area of cardiovascular disease; **and** (I-R[, II-R])

*[B. Registered nurses assigned to the emergency department at level III and IV STEMI centers shall complete and document a minimum of six (6) hours of continuing education every two (2) years in the area of cardiovascular disease; and (III-R, IV-R)]*

*[C.]* B. Registered nurses assigned to the emergency department at STEMI centers shall maintain core competencies in the care of the STEMI patient annually as determined by the STEMI center. Continuing education earned in training to

maintain these competencies may count toward continuing education requirements. (I-R, II-R, III-R, IV-R)

(F) Registered nurses assigned to the intensive care unit who provide care to STEMI patients shall complete the following continuing education requirements:

1. Registered nurses in the intensive care unit shall complete and document a minimum of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (I-R[, II-R])

(G) Registered nurses and clinical staff assigned to the cardiac catheterization lab shall complete the following continuing education requirements:

1. Registered nurses and clinical staff shall complete and document a minimum of eight (8) hours of continuing education every year in the area of acute coronary syndrome. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (I-R[, II-R])

(H) Registered nurses assigned to the intermediate care unit shall complete the following continuing education requirements:

1. Intermediate care unit registered nurses in level I [and level II] STEMI centers shall complete and document a minimum of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility; and]. (I-R[, II-R])

[2. Intermediate care unit registered nurses in level III STEMI centers shall complete and document a minimum of eight (8) hours of continuing education every two (2) years in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (III-R)]

**AUTHORITY:** section[s] 190.185, **RSMo 2016**, and section 190.241, **RSMo Supp. [2012] 2022**. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at [Nicole.Gamm@health.mo.gov](mailto:Nicole.Gamm@health.mo.gov) or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

## TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES

### Division 30 – Division of Regulation and Licensure Chapter 40 – Comprehensive Emergency Medical Services Systems Regulations

#### PROPOSED RULE

#### 19 CSR 30-40.792 Adult Trauma and Pediatric Field Triage and Transport Protocol

**PURPOSE:** This rule establishes protocols for transporting suspect-

ed trauma patients by severity and time of onset to the trauma centers where resources exist to provide appropriate care.

**PUBLISHER'S NOTE:** The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) All ground and air ambulances shall use the Adult and Pediatric Trauma Field Triage and Transport Protocol unless the department has waived the requirements of the rule pursuant to section 190.200.3, **RSMo**, and 19 CSR 30-40.790.

(A) Assess for life-threatening conditions (such as serious airway or respiratory compromise or immediate life-threatening conditions that cannot be managed in the field).

1. If there are life-threatening conditions, then transport patient to the closest trauma center or hospital emergency department capable of managing the condition.

2. If there are no life-threatening conditions, then assess the patient using the *2021 National Guideline for the Field Triage of Injured Patients*, which is incorporated by reference in this rule as published by the American College of Surgeons and available online at [www.facs.org/quality-programs/trauma/systems/field-triage-guidelines/](http://www.facs.org/quality-programs/trauma/systems/field-triage-guidelines/) or from the American College of Surgeons, 633 N. Saint Clair St., Chicago, Illinois 60611-3295. This rule does not incorporate any subsequent amendments or additions.

A. If the patient is fifteen (15) years of age or older and meets any one (1) of the listed red criteria, then transport the patient to a level I or II trauma center according to local and regional process. If the patient is younger than fifteen (15) years old, then transport to a level I or II pediatric trauma center or a level I or II pediatric capable trauma center according to local and regional process. A pediatric capable trauma center is an adult trauma center designated by the department that admits fewer than one hundred (100) injured children younger than fifteen (15) years of age. The local and regional process shall take into consideration time for transport, patient condition, and treatment window (within 60 minutes from time of injury to the appropriate trauma center) with the goal to secure the appropriate treatment for the patient as expeditiously as possible via ground and/or air. The local and regional process for bi-state regions accounts for out-of-state transport when appropriate.

B. If the patient is fifteen (15) years of age or older and meets any one (1) of the listed yellow criteria, then transport the patient to a level I, II or III trauma center. If the patient is less than fifteen (15) years old, then transport to a level I, II, or III pediatric trauma center or a level I, II or III pediatric capable trauma center according to local and regional process. Local and regional process shall take into consideration time for transport, patient condition, and treatment window (within 60 minutes from time of injury to the appropriate trauma center) with the goal to secure the appropriate treatment for the patient as expeditiously as possible via ground and/or air. The local and regional process for bi-state regions accounts for out-of-state transport when appropriate.

(2) When initial transport from the scene of illness or injury to a trauma patient is prolonged, the trauma patient may be transported to the nearest appropriate facility for stabilization prior to transport to an appropriate trauma center.

(3) Nothing in this rule shall restrict an individual patient's right to refuse transport to a recommended destination. All ground

and air ambulances shall have a written process in place to address patient competency and refusal of transport to the recommended destination.

*AUTHORITY: section 190.185, RSMo 2016, and sections 190.200 and 190.243, RSMo Supp. 2022. Original rule filed Nov. 21, 2022.*

*PUBLIC COST: This proposed rule will cost state agencies or political subdivisions a range of zero to two hundred fifty thousand dollars (\$0 to \$250,000) in the first year and annually thereafter.*

*PRIVATE COST: This proposed rule will cost private entities a range of zero to two hundred fifty thousand dollars (\$0 to \$250,000) in the first year and annually thereafter.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Nicole Gamm at [Nicole.Gamm@health.mo.gov](mailto:Nicole.Gamm@health.mo.gov) or Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**FISCAL NOTE  
PUBLIC COST**

- I. Department Title: Missouri Department of Health and Senior Services**  
**Division Title: Division of Regulation and Licensure**  
**Chapter Title: Chapter 40- Comprehensive Emergency Medical Services System**

<b>Rule Number and Name:</b>	<b>19 CSR 30-40.792 Adult Trauma and Pediatric Field Triage and Transport Protocol</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>ground service licensees (public)</b>	<b>\$0 to \$250,000 for the first year and annually thereafter.</b>
	<b>Total= \$0 to \$250,000 for the first year and annually thereafter.</b>

**III. WORKSHEET**

\$0-\$250,000- range for the first year and annually thereafter.

**IV. ASSUMPTIONS**

There are approximately 220 ground services licensed in Missouri with 201 of these ground services being public and twenty-nine (29) of these services being private. There are approximately twelve (12) air services licensed in Missouri with all of these air services being private. Ground and air services have been transporting to trauma centers without a specific transport protocol for many years as section 190.243, RSMo required this and most medical directors included this transport into the services' medical protocols.

Additionally, several emergency medical service ("EMS") regions have had community plans in place, which were approved by the department, regarding where to transport trauma patients in their EMS regions. There are currently three EMS regions (Kansas City, St. Louis and Central Missouri) with department approved community plans. In these regions, EMS can follow the department approved community plans pursuant to this proposed rule and do not have to follow this proposed rule. Therefore, there should not be much of a cost for these regions because most if not all of the services will be utilizing the department approved plan for trauma transport in their regions not the department trauma transport protocol.

The department is providing this fiscal note as there may be differences between the criteria that medical directors currently rely on in their medical protocols to determine what is a trauma and what medical criteria will now be required through this proposed rule. The EMS services can still use their local and regional process, but there is a potential for there to be more trauma transport if the medical criteria in this proposed rule is different from what the services currently have in their medical protocols.

EMS services get paid for their ambulance calls through patients by the patients' insurance/Medicaid/Medicare. However, there still may be costs associated with staffing/ambulances related to this proposed rule for those three (3) EMS regions (Northwest, Southwest and Southeast) that will follow this proposed rule or any other ground or air service that does not want to follow their community plans in the EMS regions that have community plans already approved by the department.

It is difficult to know what this cost may be at this time. Therefore, the department is projecting a range from \$0 to \$250,000 annually based on any trauma transports that will result based on the differences in the new trauma criteria in this proposed rule that will prompt transport to a trauma center different than the medical directors' medical protocols. Additionally, any payment the service receives for the transport will be subtracted from the cost to the EMS service. Thus, the net result after payment to the respective EMS services will be a range from \$0 to \$250,000 for publicly owned ambulance services.

**FISCAL NOTE  
PRIVATE COST**

- I. Department Title: Missouri Department of Health and Senior Services**  
**Division Title: Division of Regulation and Licensure**  
**Chapter Title: Chapter 40- Comprehensive Emergency Medical Services System**

<b>Rule Number and Name:</b>	<b>19 CSR 30-40.792 Adult Trauma and Pediatric Field Triage and Transport Protocol</b>
<b>Type of Rulemaking:</b>	<b>Proposed Rule</b>

**II. SUMMARY OF FISCAL IMPACT**

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
<b>ground service licensees and air service licensee (private)</b>	<b>\$0 to \$250,000 for the first year and annually thereafter.</b>
	<b>Total= \$0 to \$250,000 for the first year and annually thereafter.</b>

**III. WORKSHEET**

\$0-\$250,000- range for the first year and annually thereafter.

**IV. ASSUMPTIONS**

There are approximately 220 ground services licensed in Missouri with 201 of these ground services being public and nineteen (19) of these services being private. There are approximately twelve (12) air services licensed in Missouri with all of these air services being private. Ground and air services have been transporting to trauma centers without a specific transport protocol for many years as section 190.243, RSMo required this and most medical directors included this transport into the services' medical protocols.

Additionally, several emergency medical service ("EMS") regions have had community plans in place, which were approved by the department, regarding where to transport trauma patients in their EMS regions. There are currently three EMS regions (Kansas City, St. Louis and Central Missouri) with department approved community plans. In these regions, EMS can follow the department approved community plans pursuant to this proposed rule and do not have to follow this proposed rule. Therefore, there should not be much of a cost for these regions because most if not all of the services will be utilizing the department approved plans for trauma transport in their regions not the department's trauma transport protocol.

The department is providing this fiscal note as there may be differences between the criteria that medical directors currently rely on in their medical protocols to determine

what is a trauma and what medical criteria will now be required through this proposed rule. The EMS services can still use their local and regional process, but there is a potential for there to be more trauma transport if the medical criteria in this proposed rule is different from what the services currently have in their medical protocols.

EMS services get paid for their ambulance calls through patients by the patients' insurance/Medicaid/Medicare. However, there still may be costs associated with staffing/ambulances related to this proposed rule for those three (3) EMS regions (Northwest, Southwest and Southeast) that will follow this proposed rule or any other ground or air service that does not want to follow their community plans in the EMS regions that have community plans already approved by the department.

It is difficult to know what this cost may be at this time. Therefore, the department is projecting a range from \$0 to \$250,000 annually based on any trauma transports that will result based on the differences in the new trauma criteria in this proposed rule that will prompt transport to a trauma center different than the medical directors' medical protocols. Additionally, any payment the service receives for the transport will subtracted from the cost to the EMS service. Even though there are not many private ground ambulances, there are twelve (12) private air ambulances. While air ambulances many times will be transferring hospital patients to a higher level of trauma care, there may be times where they respond to emergencies and transport the patient to the appropriate trauma center. Air ambulance transport costs are higher than ground ambulance transports and not all of these costs may be reimbursed back from the insurance/government paying for the transport. Thus, the net result after payment to the respective EMS services will be a range from \$0 to \$250,000 for privately owned ambulance services due to the higher potential costs of air ambulance transports.

## TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES

### Division 73 – Missouri Board of Nursing Home Administrators Chapter 2 – General Rules

#### PROPOSED AMENDMENT

**19 CSR 73-2.130 Notice of Change of [Address] Contact Information and Missouri Administrator Employment.** The department is amending the rule title and section (1).

*PURPOSE:* The purpose of the amendment is to modify the number of days for an administrator to provide notification to the board and clarify the information that must be updated with the board.

(1) Each administrator shall notify the board office of his/her current contact information within *[twenty-one (21)] ten (10) calendar* days of change *[personal contact information, facility employment, or both. Contact information shall include the following: mailing address, email, and telephone number(s).]* for any of the following:

(A) Personal contact information, which shall include administrator license number, personal mailing address, email, and telephone number(s); and

(B) Missouri administrator employment, which shall include, administrator license number, facility name, mailing address, telephone number(s), and employment dates.

*AUTHORITY:* section 344.070, RSMo [Supp. 2010] 2016. This rule was previously filed as 13 CSR 73-2.130. Original rule filed May 13, 1980, effective Aug. 11, 1980. Amended: Filed Oct. 17, 1985, effective March 14, 1986. Moved to 19 CSR 73-2.130, effective March 3, 2003. Amended: Filed June 15, 2011, effective Jan. 30, 2012. Amended: Filed Nov. 28, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of in opposition to this proposed amendment with Sally McKee, Missouri Board of Nursing Home Administrators, 3418 Knipp Drive, PO Box 570, Jefferson City, MO 65102, or via email at Sally.McKee@health.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

## TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE

### Division 2010 – Missouri State Board of Accountancy Chapter 2 – General Rules

#### PROPOSED RULE

#### 20 CSR 2010-2.085 Reinstatement of Firm Permit

*PURPOSE:* This rule establishes requirements for reinstatement of permit to practice for CPA firms.

(1) The board may reinstate the permit of any CPA firm provided—

(A) The firm submits a completed reinstatement application and applicable fees.

(2) A firm shall submit a reinstatement application where the permit has expired for more than two (2) months or has previously been suspended or revoked.

(3) In the event of application for reinstatement of a permit to practice, wherein the CPA firm had been previously suspended or revoked by the board, the board may modify the earlier discipline by placing requirements or restrictions upon the reinstated permit. Such modifications may include probation, pre-issuance reviews, and other such requirements as permitted by law and determined by the board.

(4) A firm making application for reinstatement that has been practicing public accounting in Missouri without an active permit shall not be reinstated until all required fees and delinquent fees have been paid, which were not paid previously.

(5) The provisions of this rule are declared severable. If any provision of this rule is held invalid by a court of competent jurisdiction, the remaining provisions of this rule shall remain in full force and effect, unless otherwise determined by a court of competent jurisdiction to be invalid.

*AUTHORITY:* sections 324.038 and 326.262, RSMo 2016, and section 326.289, RSMo Supp. 2022. Original rule filed Dec. 1, 2022.

*PUBLIC COST:* This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed rule with the Board of Accountancy, PO Box 613, Jefferson City, MO 65102, by facsimile at (573) 751-0012, or via email at mosba@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

## TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE

### Division 2010 – Missouri State Board of Accountancy Chapter 2 – General Rules

#### PROPOSED AMENDMENT

**20 CSR 2010-2.160 Fees.** The board is amending section (1).

*PURPOSE:* This amendment combines and clarifies existing fees, increases delinquent and inactive fees, and establishes reinstatement fees.

(1) The following fees are established by the Missouri State Board of Accountancy for **certified public accountants (CPA) and certified public accounting firms**.

(A) <i>[Initial]</i> Reciprocity Fee	<i>[\$75.00]</i> <b>\$165.00</b>
(B) Wall Hanging Fee ( <b>duplicate</b> )	\$ 25.00
<i>[(C) Firm Permit Fee (professional corporation, sole proprietor, partnership, limited liability company)]</i>	<b>\$90.00]</b>
<i>[(D)](C) [Individual] CPA License Fee (initial)</i>	<i>[\$65.00]</i> <b>\$90.00</b>
<i>[(E)](D) [Individual] CPA License Fee (biennial renewal)</i>	\$ 80.00
(E) CPA Inactive License Fee ( <b>initial</b> )	<b>\$ 50.00</b>
(F) CPA Inactive License Fee ( <b>biennial renewal</b> )	<b>\$ 50.00</b>

(G) CPA Reinstatement of License Fee	\$200.00
(H) Firm Permit Fee (initial)	\$ 90.00
(I) Firm Permit Fee (annual renewal)	\$ 90.00
(J) Reinstatement of CPA Firm Permit Fee	\$200.00
[(F)](K) Replacement Fee (license or permit)	\$10.00
[(G)](L) Delinquent fee for failure to obtain a permit or license, or timely renew a permit or license (per month or portion of a month) –	
1. Firms [practicing public accounting in this state (sole proprietors, limited liability companies, partnerships and professional corporations) (per month or portion of a month)	\$ 25.00] \$ 50.00
2. [All c]Certified public accountants [(per month or portion of a month) (not to exceed \$100.00)	\$ 25.00] \$ 50.00
[(H) Inactive License Fee (initial)	\$ 25.00
(I) Inactive License Fee (biennial renewal)	\$ 25.00]
[(J)](M) [Insufficient Funds] Bad Check Fee	\$ 25.00

**AUTHORITY:** sections 326.262 and 326.271, RSMo 2016, and sections 326.277, 326.280, 326.283, 326.286, and 326.289, RSMo Supp. [2020] 2022. This rule originally filed as 4 CSR 10-2.160. Emergency rule filed Aug. 6, 1981, effective Aug. 16, 1981, expired Dec. 10, 1981. Original rule filed Aug. 6, 1981, effective Dec. 11, 1981. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 1, 2022.

**PUBLIC COST:** This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

**PRIVATE COST:** This proposed amendment will cost private entities thirty-seven thousand dollars (\$37,000) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Accountancy, PO Box 613, Jefferson City, MO 65102, by facsimile at (573) 751-0012, or via email at [mosba@pr.mo.gov](mailto:mosba@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**PRIVATE FISCAL NOTE****I. RULE NUMBER**

**Title 20 -Department of Commerce and Insurance**  
**Division 2010—Missouri State Board of Accountancy**  
**Chapter 2 - General Rules**  
**Proposed Amendment to 20 CSR 2010-2.160 Fees**

**II. SUMMARY OF FISCAL IMPACT**

Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimated costs for the life of the rule by affected entities:
10	Delinquent Fee - Firms ( Fee Increase @ \$25)	\$250
52	Delinquent Fee - Individuals ( Fee Increase @ \$25)	\$1,300
77	Reinstatement of CPA license ( Fee @ \$200)	\$15,400
19	Reinstatement of CPA firm permit ( Fee @ \$200)	\$3,800
200	Inactive License - Initial ( Fee Increase @ \$25)	\$5,000
450	Inactive License - Renewal ( Fee Increase @ \$25)	\$11,250
<b>Estimated Revenue Beginning in FY23 and Annually Thereafter</b>		<b>\$37,000</b>

**III. WORKSHEET**

See Table Above

**IV. ASSUMPTION**

1. The firm renewal fee, initial reciprocity fee and the individual license fee do not represent an increase in costs. The fees incorporate the fees currently paid by applicants into one fee. The reciprocity fee incorporate the reciprocity (\$75), initial license (\$65) and wall hanging (\$25) into one fee of \$165. The individual fee incorporates the license fee (\$65) and wall hanging (\$25) into one fee of \$90.

2. Firm delinquent fees – The increase in this fee due to late renewal will be reduced to two months at the maximum due. Firms will be required to reinstatement licensure once expired. The reinstatement process being proposed in rule amendment 20 CSR 2010-2.085. Firms will move to expired status upon the end of the renewal period and require reinstatement.
3. CPA delinquent Fees – The increase in this fee due to late renewal will be reduced to three months as the maximum amount due for late renewal. Individuals will be required to reinstate their license after the late renewal period. In addition, delinquent fees will be offset by the anticipated reduction in penalties that often accompany continuing education deficit that results from individual CPAs renewing late into the two year late renewal window. Active licensure reverts back to the beginning of when the license status expired, thus requiring continuing education for the entire period in which the license was previously expired. CPA deficits typically result in disciplinary action with monetary penalties.
4. Reinstatements - CPA – The board anticipates an average of 77 reinstatements annually. With the fee increase this average would result in an increase of \$15,400 annually.
5. Reinstatements – Firms – The reinstatement process will be new but the currently requirement when a firm license expires to go through a process of renewing each expired or lapsed year individually at the annual renewal rate of \$90 regardless of the number of years involved. The reinstatement process (as proposed in new rule) will allow for a one time fee of \$200 to reinstate licensure regardless of the total years expired or lapsed.
6. Inactive (initial) – The board anticipates approximately 200 CPAs will place their license in inactive status annually at renewal. The anticipated cost of this increase is \$5000.
7. Inactive (renewals) The board anticipates approximately 450 CPA will renew their inactive license annually for an increase in funding of \$11,250. However, there is an overall reduction of funding to the board as inactive licensee renewal fees are \$30 less than active licensure renewal fee (\$80). There is a reduction in funding to the program if \$13,500.
8. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

Note: The division is statutorily obligated to enforce and administer the provisions of sections 326.250 to 326.331, RSMo. Pursuant to section 326.319, RSMo, the board shall by rule and regulation set the amount of fees authorized by section 326.319, RSMo, so that the revenue produced is sufficient, but not excessive, to cover the cost and expense to the division for administering the provisions of sections 326.250 to 326.331, RSMo.

**TITLE 20 – DEPARTMENT OF COMMERCE AND  
INSURANCE**

**Division 2010 – Missouri State Board of Accountancy  
Chapter 3 – Professional Ethics – Rules of Conduct**

**PROPOSED AMENDMENT**

**20 CSR 2010-3.060 Other Responsibilities and Practices.** The board is amending section (7).

*PURPOSE:* The amendment clarifies the methods in which the board may deliver communication to a licensee.

(7) A licensee, when requested, shall respond to communications from the board within thirty (30) days of **hand delivery, verified electronic mail (read receipt), or** mailing of these communications by registered or certified mail.

*AUTHORITY:* section[s] 326.271, [326.280, and 326.289.] RSMo [Supp. 2012] 2016, and sections 326.280 and 326.289, RSMo Supp. 2022. This rule originally filed as 4 CSR 10-3.060. Original rule filed July 3, 1975, effective Aug. 25, 1975. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 1, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Accountancy, PO Box 613, Jefferson City, MO 65102, by facsimile at (573) 751-0012, or via email at mosba@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**TITLE 20 – DEPARTMENT OF COMMERCE AND  
INSURANCE**

**Division 2010 – Missouri State Board of Accountancy  
Chapter 4 – Continuing Education Requirements**

**PROPOSED AMENDMENT**

**20 CSR 2010-4.031 Continuing Professional Education (CPE) Documentation.** The board is amending subsection (1)(E).

*PURPOSE:* This amendment clarifies language on CPE deficiencies.

(1) Continuing Professional Education (CPE) Records.

(E) Beginning January 1, 2021, a licensee in good standing may cure their CPE deficiencies due to a disallowance of courses or hours by the board as follows:

1. A licensee shall have thirty (30) days from the date of notice of the board's assertion of a licensee's failure to comply with the annual qualifying CPE requirements to **provide the acceptable documentation set forth in subsection (1)(B) above, or** obtain qualifying CPE hours; **[and]**

2. Licensees requesting to use the above cure period shall submit a written application to the board on a form provided by the board no later than thirty (30) days from the date of the board's notice[.]; **and**

3. **To cure a deficiency, a licensee must, within thirty (30) days of the notice to cure –**

**A. Submit the acceptable documentation for hours denied; and/or**

**B. Complete new CPE courses and provide acceptable documentation.**

*AUTHORITY:* section 326.271, RSMo 2016, and section 326.310, RSMo Supp. [2020] 2022. This rule originally filed as 4 CSR 10-4.031. Original rule filed April 5, 2004, effective July 30, 2004. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Dec. 1, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Accountancy, PO Box 613, Jefferson City, MO 65102, by facsimile at (573) 751-0012, or via email at mosba@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**TITLE 20 – DEPARTMENT OF COMMERCE AND  
INSURANCE**

**Division 2010 – Missouri State Board of Accountancy  
Chapter 4 – Continuing Education Requirements**

**PROPOSED AMENDMENT**

**20 CSR 2010-4.035 Inactive, Expired, and Lapsed Licenses.** The board is amending the title, sections (5) and newly numbered (6), and renumbering as necessary.

*PURPOSE:* This amendment clarifies language on expired and lapsed licenses.

(5) Licensees may allow their license to expire in lieu of an inactive license status. An individual not applying for renewal continues to hold an expired license and may apply for late renewal *[until the license period ends. At the end of the license period]* through December 31 of the year the license is expired. Individuals who apply for a late license renewal are deemed to hold the license for the entire calendar year and must comply with the continuing professional education requirements. After December 31, the individual is deemed to hold a lapsed license.

(6) *[Licensees]* Individuals who hold an expired or lapsed license shall not practice public accounting nor use the CPA designation in any form, as provided by section 326.292, RSMo.

*[(6)](7)* Individuals who hold a lapsed or inactive license may return to active status by applying for reinstatement of license as defined in 20 CSR 2010-2.075.

*AUTHORITY:* section 326.262, RSMo 2016, and section 326.286.6, RSMo Supp. [2019] 2022. Original rule filed Feb. 23, 2010, effective Aug. 30, 2010. Amended: Filed May 20, 2019, effective Dec. 30, 2019. Amended: Filed Dec. 1, 2022.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

*PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Board of Accountancy, PO Box 613, Jefferson City, MO 65102, by facsimile at (573) 751-0012, or via email at mosba@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, PO Box 4, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 751-3166, or via email at healingarts@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

**TITLE 20 – DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2150 – State Board of Registration for the  
Healing Arts  
Chapter 2 – Licensing of Physicians and Surgeons**

**PROPOSED AMENDMENT**

**20 CSR 2150-2.080 Physician Licensure Fees.** The board is amending subsection (1)(A).

*PURPOSE: The amendment incorporates the preceptorship fee to the permanent physician licensure and renewal fee.*

(1) The following fees are established by the State Board of Registration for the Healing Arts:

(A) Physician

1. Assistant Physician
  - A. Licensure Fee \$ 25
  - B. Renewal Fee \$ 25
  - C. Prescriptive Authority Fee \$ 25
2. Contiguous State License
  - A. Licensure Fee \$ 25
  - B. Renewal Fee \$ 25
3. Limited License
  - A. Licensure Fee \$ 25
  - B. Renewal Fee \$ 25
4. Permanent Physician
  - A. Licensure Fee ~~[\$ 75]~~ **\$ 82**
  - B. Reinstatement Fee \$ 75
  - C. Renewal Fee ~~[\$100]~~ **\$107**
5. Temporary Physician
  - A. Conditional Temporary License Fee \$ 25
  - B. Temporary License Fee \$ 25
  - C. Temporary License Renewal Fee \$ 25
6. Visiting Professor
  - A. Licensure Fee \$ 25
  - B. Renewal Fee \$ 25

**AUTHORITY: section 135.690, RSMo Supp. 2022, and sections 334.090.2 and 334.125, RSMo 2016.** This rule originally filed as 4 CSR 150-2.080. Emergency rule filed July 1, 1981, effective July 11, 1981, expired Nov. 8, 1981. Original rule filed July 14, 1981, effective Oct. 11, 1981. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 30, 2022.

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities approximately two hundred seventeen thousand two hundred eighty dollars (\$217,280) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.*

**PRIVATE FISCAL NOTE****I. RULE NUMBER****Title 20 -Department of Commerce and Insurance****Division 2150—State Board of Registration for the Healing Arts****Chapter 2 – Licensing of Physicians and Surgeons****Proposed Amendment to 20 CSR 2150-2.080 Physician Licensure Fees****II. SUMMARY OF FISCAL IMPACT**

<b>Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:</b>	<b>Classification by type of the business entities which would likely be affected:</b>	<b>Estimated costs for the life of the rule by affected entities:</b>
2,540	Permanent Physician - Application ( Fee Increase @ \$7)	\$17,780
28,500	Permanent Physician - Renewal ( Fee Increase @ \$7)	\$199,500
	<b>Estimated Cost Beginning in FY23 and Annually Thereafter</b>	<b>\$217,280</b>

**III. WORKSHEET**

See Table Above

**IV. ASSUMPTION**

1. The board is statutorily obligated to collect the seven dollar (\$7) preceptorship fee under section 339.690, RSMo. The revenue produced will be deposited in the Medical Preceptor Fund to be administered by the Department of Health and Senior Services.
2. Actual cost may vary based on the number of applications received.
3. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

**TITLE 20 – DEPARTMENT OF COMMERCE AND  
INSURANCE  
Division 2150 – State Board of Registration for the  
Healing Arts  
Chapter 7 – Licensing of Physician Assistants**

**PROPOSED AMENDMENT**

**20 CSR 2150-7.200 Physician Assistant Licensure Fees.** The board is amending subsection (1)(A).

*PURPOSE: The amendment incorporates the preceptorship fee to the permanent physician assistant licensure and renewal fees.*

(1) The following fees are established by the Missouri State Board of Registration for the Healing Arts in conjunction with the director of the Division of Professional Registration:

(A) Physician Assistant

- |  |                        |
|--|------------------------|
| 1. Licensure Fee   | <del>[\$25]</del> \$28 |
| 2. Renewal Fee   | <del>[\$25]</del> \$28 |
| 3. Temporary Licensure Fee   | \$25                   |
| 4. Temporary Licensure Renewal Fee                                   | \$25                   |
| 5. Certificate of Controlled Substance<br>Prescriptive Authority Fee | \$25                   |

**AUTHORITY: sections 135.690, 334.735, and 334.736, RSMo Supp. 2022, and sections 334.125, [334.735, 334.736,] 334.738, and 334.743, RSMo 2016. This rule originally filed as 4 CSR 150-7.200. Emergency rule filed Sept. 15, 1992, effective Sept. 25, 1992, expired Jan. 22, 1993. Original rule filed April 2, 1992, effective Dec. 3, 1992. For intervening history, please consult the **Code of State Regulations**. Amended: Filed Nov. 30, 2022.**

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.*

*PRIVATE COST: This proposed amendment will cost private entities approximately five thousand two hundred eighty-three dollars (\$5,283) annually for the life of the rule. It is anticipated that the costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.*

**NOTICE TO SUBMIT COMMENTS:** Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Board of Registration for the Healing Arts, PO Box 4, 3605 Missouri Boulevard, Jefferson City, MO 65102, by facsimile at (573) 751-3166, or via email at [healingarts@pr.mo.gov](mailto:healingarts@pr.mo.gov). To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.

**PRIVATE FISCAL NOTE****I. RULE NUMBER****Title 20 -Department of Commerce and Insurance****Division 2150—State Board of Registration for the Healing Arts****Chapter 7—Licensing of Physician Assistants****Proposed Amendment to 20 CSR 2150-7.200 Physician Assistant Licensure Fees****II. SUMMARY OF FISCAL IMPACT**

<b>Estimate the number of entities by class which would likely be affected by the adoption of the proposed rule:</b>	<b>Classification by type of the business entities which would likely be affected:</b>	<b>Estimated costs for the life of the rule by affected entities:</b>
256	Physician Assistant - Application ( Fee Increase @ \$3)	\$768
1,505	Physician Assistant - Renewal ( Fee Increase @ \$3)	\$4,515
	<b>Estimated Cost Beginning in FY23 and Annually Thereafter</b>	<b>\$5,283</b>

**III. WORKSHEET**

See Table Above

**IV. ASSUMPTION**

1. The board is statutorily obligated to collect the three dollar (\$3) preceptorship fee under section 339.690, RSMo. The revenue produced will be deposited in the Medical Preceptor Fund to be administered by the Department of Health and Senior Services.
2. Actual revenue increases may vary based on applications received.
3. It is anticipated that the total costs will recur for the life of the rule, may vary with inflation, and are expected to increase at the rate projected by the Legislative Oversight Committee.

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted that has been changed from the text contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments that are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

**TITLE 5 – DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 20 – Division of Learning Services  
Chapter 400 – Office of Educator Quality**

**ORDER OF RULEMAKING**

By the authority vested in the State Board of Education (board) under sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. 2022, the board amends a rule as follows:

5 CSR 20-400.610 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2022 (47 MoReg 1077-1078). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received two (2) comments on the proposed amendment.

COMMENT #1: The Missouri School Boards' Association requested that the department change the statement "Understands a variety of strategies for building relationships and working cooperatively with board members" to "Understands a variety of strategies for building relationships and working cooperatively with the board" in subpart (4)(A)5.B.(IV)(g).

RESPONSE AND EXPLANATION OF CHANGE: The department

agrees with the proposed change. The amendment has been revised to include the new wording.

COMMENT #2: The Office of Educator Quality recommends that the word "to" be added after the word "practices" in subpart (4)(A)5.B.(V)(a).

RESPONSE AND EXPLANATION OF CHANGE: The department added the word "to" to subpart (4)(A)5.B.(V)(a).

**5 CSR 20-400.610 Certification Requirements for Initial Administrator Certificate**

(4) An applicant for a Missouri Initial Administrator Certificate (Superintendent, Kindergarten-Grade 12) who possesses good moral character may be granted an Initial Administrator Certificate (Superintendent, Kindergarten-Grade 12) subject to the certification requirements found in 5 CSR 20-400.500 and the following additional certification requirements specific to Superintendents:

(A) Professional Requirements. An Initial Administrator Certificate, valid for a period of four (4) years from the date of issuance, will be issued to applicants meeting the following requirements:

1. A permanent or professional Missouri certificate of license to teach;

2. A minimum of three (3) years of experience as a building- or district-level administrator at a public or accredited nonpublic school;

3. The applicant must achieve a score equal to or in excess of the qualifying score on the required exit assessment(s) as defined in 5 CSR 20-400.310 and 5 CSR 20-400.440. The official score shall be submitted to the department;

4. Completion of a course in Psychology/Education of the Exceptional Child;

5. Completion of an educational specialist or advanced degree program in educational leadership and recommendation from the designated official of a regionally accredited college or university or other education leadership program approved by the department which shall include:

A. Coursework must be at the graduate level and fall within the following five (5) domains of district-level leadership –

(I) Visionary Leadership;

(II) Instructional Leadership;

(III) Managerial Leadership;

(IV) Relational Leadership; and

(V) Innovative Leadership;

B. Knowledge and/or competency in each of the following areas:

(I) Visionary Leadership –

(a) Knows the importance of a vision and how it relates to the core values and culture of the district;

(b) Understands the importance of all stakeholders knowing the collective mission, vision, and core values;

(c) Understands how multiple sources of data are connected to a mission, vision, and core values;

(II) Instructional Leadership –

(a) Understands how standards apply to horizontal and vertical alignment of local curricula and content areas;

(b) Understands a variety of research-based instructional practices and how to appropriately match them to learning content;

(c) Understands legal implications impacting instruction and ensures meaningful feedback related to effective teacher and leader practice;

(d) Understands the importance of assessing

student learning using a variety of formal and informal assessments;

(e) Understands the importance of multiple strategies for analyzing data to inform the instructional process; and

(f) Understands the principles of adult learning and how these help develop principal and teacher capacity;

(III) Managerial Leadership –

(a) Knows how safe and functional district facilities and grounds support student learning;

(b) Understands how routines, protocols, procedures, policies, and technology support the district environment;

(c) Understands tools used to determine key attributes of effective personnel;

(d) Understands the necessity of establishing and communicating clear expectations, guidelines, policies, and procedures respecting the rights of all staff and students;

(e) Understands the role of observation, feedback, documentation, and intervention for improving or removing personnel and the legal and ethical decisions in creating an effective educator evaluation process;

(f) Is knowledgeable of requirements regarding personnel records, laws, and reports;

(g) Understands the statutory requirements that affect how a district budget works and the major sources of revenue to support district goals and priorities; and

(h) Understands the statutory requirements that affect how non-fiscal resources support district goals and priorities;

(IV) Relational Leadership –

(a) Knows how and why analysis of student demographics is used to determine the overall diversity of a district and its impact on the teaching and learning process;

(b) Understands the legal implications of in-district and out-of-district strategies and resources available in supporting the well-being of each student;

(c) Understands how to build positive and ethical relationships in support of student learning and well-being;

(d) Understands the importance of building effective, ethical relationships with all staff;

(e) Understands how to develop a culture of support and respect among staff and in the community;

(f) Serves as a district leader and understands the importance of building leadership capacity in a district;

(g) Understands a variety of strategies for building relationships and working cooperatively with the board; and

(h) Recognizes the impact the larger political, social, economic, legal, and cultural issues can have on educational issues in the school district;

(V) Innovative Leadership –

(a) Recognizes knowledge, skills, and best practices to support continuous professional growth;

(b) Understands the need for professional networks as a key element of professional growth;

(c) Understands the importance of reflection and a commitment to ongoing learning;

(d) Understands the importance of feedback for improving performance;

(e) Understands how time management is a key factor for maintaining a focus on district priorities;

(f) Recognizes that beliefs based on new knowledge, understandings, and technology are used as a catalyst for change;

(g) Understands the need to be flexible and willing to vary an approach when circumstances change; and

C. Directed field experiences in superintendency of at least three (3) semester hours.

## TITLE 5 – DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

### Division 25 – Office of Childhood

### Chapter 100 – Early Childhood Development

#### ORDER OF RULEMAKING

By the authority vested in the State Board of Education (board) under sections 161.092 and 178.691-178.699, RSMo 2016 and Supp. 2022, the board amends a rule as follows:

5 CSR 25-100.330 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 1, 2022 (47 MoReg 1078-1079). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Department of Elementary and Secondary Education (department) received two (2) comments on this proposed amendment.

*PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

COMMENT #1: Abby Susman, parent educator, commented on reflective supervision, developmental screenings, documentation, and professional development. Ms. Susman provided suggestions regarding changing minor components of the current program.

RESPONSE: These comments were taken into consideration and the department believes the current rule sufficiently meets and explains the needs and structure of the program. No changes have been made to the amendment as a result of these comments.

COMMENT #2: The department, in reviewing this proposed amendment, determined that clarification is necessary, and in response revised paragraph (1)(A)8. and incorporated the *Early Childhood Development Act (ECDA) Administrative Manual* to ensure clear requirements and interpretation of this rule.

RESPONSE AND EXPLANATION OF CHANGE: The department has modified the amendment by revising paragraph (1)(A)8. and by adding subsection (1)(B). Stakeholders, including the Parent Education Steering Committee and the Parents as Teachers National Center, had opportunities to review and provide feedback regarding the *ECDA Administrative Manual*.

#### 5 CSR 25-100.330 General Provisions Governing Programs Authorized Under the Early Childhood Development Act

(1) All programs and projects carried out by school districts under the Early Childhood Development Act (ECDA) shall be conducted in conformity with –

(A) The school district's annual application for district program approval under the ECDA, pursuant to applicable state laws and regulations and the following:

1. The school district shall designate a supervisor who will be responsible for the oversight, delivery, and evaluation of

the parent education program including presenting the goals, objectives, and effectiveness of the program regularly to the local school board;

2. The school district shall establish a Community Advisory Committee or utilize an existing committee that includes key stakeholders such as families, early childhood providers, school administration, school board members, and other community leaders. The purpose of the Community Advisory Committee is to promote, plan, and evaluate the parent education program. The Community Advisory Committee shall meet, at a minimum, twice during the program year;

3. The school district shall provide families with access to qualified parent educator(s) who provide parent education services. The parent educator(s) shall be trained in an approved curriculum and complete the required hours of annual professional development;

4. The school district shall provide an approved parent education program that supports families expecting a child or who have a child under the age of kindergarten entry. These services shall be provided for, at a minimum, nine (9) months during the program year;

5. The school district shall offer families access to personal visits, developmental screenings, group connections, and a network of resources within the community to support their child's education and development;

6. The school district shall, annually, gather and summarize feedback from families regarding the services received and use the results for program improvement;

7. The school district shall utilize a systematic method for collecting, reporting, and securely storing data;

8. If a school district fails to offer or is unable to offer an approved parent education program, the district shall enter into a contract with another district, public agency, or state-approved not-for-profit agency to offer a program compliant with this rule; and

9. Funds received from the department, subject to appropriation by the General Assembly, for this parent education program cannot be used to support other programs and services provided in the school district. Prior to payment for programs and projects carried out by school districts under the ECDA, the school district shall agree to follow all procurement assurances, including monitoring, for the use of state and/or federal funds by written agreement with the department.

(B) *The Early Childhood Development Act (ECDA) Administrative Manual for Missouri Parents as Teachers Parent Education Program* contains the administrative provisions for the delivery of the state's school district parent education services. The *ECDA Manual* is hereby incorporated by reference and made a part of this rule. A copy of the *ECDA Manual* (revised September 2022) is published by and can be obtained from the Department of Elementary and Secondary Education, Office of Childhood, 205 Jefferson Street, PO Box 480, Jefferson City, MO 65102-0480, and at its website at <https://dese.mo.gov/governmental-affairs/dese-administrativerules/incorporated-reference-materials>. This rule does not incorporate any subsequent amendments or additions.

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 1 – Controlled Substances**

#### **ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 195.195, RSMo 2016, the department amends a rule as follows:

#### **19 CSR 30-1.015 Registrations and Fees is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 15, 2022 (47 MoReg 1375-1377). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## **TITLE 19 – DEPARTMENT OF HEALTH AND SENIOR SERVICES**

### **Division 30 – Division of Regulation and Licensure Chapter 1 – Controlled Substances**

#### **ORDER OF RULEMAKING**

By the authority vested in the Department of Health and Senior Services under section 195.195, RSMo 2016, the department amends a rule as follows:

#### **19 CSR 30-1.017 Registration Process is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on September 15, 2022 (47 MoReg 1378-1380). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## **TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE**

### **Division 2150 – State Board of Registration for the Healing Arts Chapter 5 – General Rules**

#### **ORDER OF RULEMAKING**

By the authority vested in the State Board of Registration for the Healing Arts under section 334.099, RSMo 2016, the board adopts a rule as follows:

#### **20 CSR 2150-5.024 HIV Post-Exposure Prophylaxis is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 15, 2022 (47 MoReg 1381-1383). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## **TITLE 20 – DEPARTMENT OF COMMERCE AND INSURANCE**

### **Division 2220 – State Board of Pharmacy Chapter 6 – Pharmaceutical Care Standards**

#### **ORDER OF RULEMAKING**

By the authority vested in the State Board of Pharmacy under

section 338.140, RSMo Supp. 2022, the board adopts a rule as follows:

**20 CSR 2220-6.025 HIV Post-Exposure Prophylaxis is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on September 15, 2022 (47 MoReg 1383-1386). No changes have been made to the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs, and other items required to be published in the *Missouri Register* by law.

**TITLE 19 – DEPARTMENT OF HEALTH AND  
SENIOR SERVICES  
Division 60 – Missouri Health Facilities  
Review Committee  
Chapter 50 – Certificate of Need Program**

**NOTIFICATION OF REVIEW:  
APPLICATION REVIEW SCHEDULE**

The Missouri Health Facilities Review Committee has initiated review of the CON applications listed below. A decision is tentatively scheduled for January 23, 2023. These applications are available for public inspection at the address shown below.

**Date Filed**

**Project Number:** Project Name  
City (County)  
Cost, Description

**12/9/2022**

**#5988 RT:** Capetown Assisted Living  
Cape Girardeau (Cape Girardeau County)  
\$1,208,700, Replace 5 ALF beds (6-mile replacement)

**12/10/2022**

**#5989 HT:** Barnes-Jewish Hospital  
St. Louis (St. Louis City)  
\$10,834,000, Replace MRI

**12/12/2022**

**#5987 HT:** Heartland Regional Medical Center  
St. Joseph (Buchanan County)  
\$1,831,327, Replace MRI

**#5978 HT:** Southeast Hospital  
Cape Girardeau (Cape Girardeau County)  
\$1,955,132, Replace 2 linear accelerators

Any person wishing to request a public hearing for the purpose of commenting on these applications must submit a written request to this effect, which must be received by January 13, 2023. All written requests and comments should be sent to –

Chairman  
Missouri Health Facilities Review Committee  
c/o Certificate of Need Program  
3418 Knipp Drive, Suite F  
PO Box 570  
Jefferson City, MO 65102  
For additional information, contact Alison Dorge at [alison.dorge@health.mo.gov](mailto:alison.dorge@health.mo.gov).

The Secretary of State is required by sections 347.141 and 359.481, RSMo, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to [adrules.dissolutions@sos.mo.gov](mailto:adrules.dissolutions@sos.mo.gov).

**NOTICE OF DISSOLUTION  
TO CREDITORS OF  
AND CLAIMANTS AGAINST  
SAFETY MATTERS MANAGEMENT, LLC.**

On August 25, 2022, Safety Matters Management, LLC ("Safety Matters Management"), a Missouri limited liability company, filed its Notice of Winding Up for a limited liability company with the Missouri Secretary of State.

You are hereby notified that if you believe you have a claim against Safety Matters Management, you must submit a summary in writing of the circumstances surrounding your claim to: Collins & Jones, P.C., Attn: Eric W. Collins, 1010 W. Foxwood Drive, Raymore, Missouri 64083. The summary of your claim must include the following information:

1. The name, address, and telephone number of the claimant;
2. The amount of the claim;
3. The date the event on which the claim is based occurred; and
4. A brief description of the nature of the debt or the basis for the claim.

All claims against Safety Matters Management will be barred unless the proceeding to enforce the claim is commenced within three years after the publication of this notice.

**NOTICE OF DISSOLUTION TO ALL  
CREDITORS OF AND CLAIMANTS AGAINST  
KCL CAPITAL, L.L.C.**

KCL Capital, L.L.C. filed its Notice of Winding Up on November 9, 2022.

The company requests that all claims be presented immediately by letter to: Malika Simmons, c/o Kansas City Life Insurance Company, 3520 Broadway, KCMO 64111. Claims must include name, address, and telephone number of claimant; amount; the basis for the claim; and documentation.

All claims against the company shall be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

# RULE CHANGES SINCE UPDATE TO CODE OF STATE REGULATIONS

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*. Citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—46 (2021) and 47 (2022). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
1 CSR 10	<b>OFFICE OF ADMINISTRATION</b>				
1 CSR 10-3.010	State Officials' Salary Compensation Schedule				47 MoReg 1457
1 CSR 15-1.207	Commissioner of Administration		This Issue		
	Administrative Hearing Commission		47 MoReg 1767		
	<b>DEPARTMENT OF AGRICULTURE</b>				
2 CSR 60-4.110	Grain Inspection and Warehousing		47 MoReg 823		
2 CSR 60-5.100	Grain Inspection and Warehousing		47 MoReg 824		
2 CSR 80-2.190	State Milk Board		47 MoReg 966	47 MoReg 1596	
2 CSR 80-5.010	State Milk Board		47 MoReg 966	47 MoReg 1596	
2 CSR 90-10.020	Weights, Measures and Consumer Protection		47 MoReg 1424		
2 CSR 90-21.010	Weights, Measures and Consumer Protection		This Issue		
	<b>DEPARTMENT OF CONSERVATION</b>				
3 CSR 10-5.900	Conservation Commission				47 MoReg 1459
3 CSR 10-7.433	Conservation Commission		47 MoReg 871	47 MoReg 1546	
3 CSR 10-7.705	Conservation Commission		47 MoReg 871	47 MoReg 1546	
3 CSR 10-9.354	Conservation Commission		47 MoReg 1501		
3 CSR 10-9.565	Conservation Commission		47 MoReg 1504		
3 CSR 10-11.115	Conservation Commission		47 MoReg 1281		
3 CSR 10-11.160	Conservation Commission		47 MoReg 1508		
3 CSR 10-11.184	Conservation Commission		47 MoReg 1281		
3 CSR 10-11.185	Conservation Commission		47 MoReg 1282		
3 CSR 10-11.215	Conservation Commission		47 MoReg 1285		
3 CSR 10-12.110	Conservation Commission		47 MoReg 1285		
3 CSR 10-12.135	Conservation Commission		47 MoReg 1285		
3 CSR 10-12.140	Conservation Commission		47 MoReg 1286		
3 CSR 10-12.145	Conservation Commission		47 MoReg 1289		
	<b>DEPARTMENT OF ECONOMIC DEVELOPMENT</b>				
4 CSR 80-6.010	Economic Development Programs		47 MoReg 1709R		
4 CSR 85-1.010	Division of Business and Community Services		47 MoReg 1709R		
4 CSR 85-3.010	Division of Business and Community Services		47 MoReg 1709R		
4 CSR 85-3.020	Division of Business and Community Services		47 MoReg 1710R		
4 CSR 85-3.030	Division of Business and Community Services		47 MoReg 1710R		
4 CSR 85-3.040	Division of Business and Community Services		47 MoReg 1710R		
4 CSR 85-3.050	Division of Business and Community Services		47 MoReg 1711R		
4 CSR 260-1.010	Division of Savings and Loan Supervision		47 MoReg 1711R		
	<b>DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION</b>				
5 CSR 20-100.210	Division of Learning Services		47 MoReg 550		
5 CSR 20-400.220	Division of Learning Services	47 MoReg 1419	47 MoReg 1424		
5 CSR 20-400.370	Division of Learning Services		47 MoReg 1425		
5 CSR 20-400.610	Division of Learning Services		47 MoReg 1077	This Issue	
5 CSR 20-500.250	Division of Learning Services		47 MoReg 780	47 MoReg 1596	
5 CSR 25-100.120	Office of Childhood		47 MoReg 1573		
5 CSR 25-100.330	Office of Childhood		47 MoReg 1078	This Issue	
5 CSR 25-200.060	Office of Childhood		47 MoReg 1430		
5 CSR 25-400.105	Office of Childhood		47 MoReg 1576		
5 CSR 25-500.102	Office of Childhood		47 MoReg 1577		
5 CSR 30-4.030	Division of Financial and Administrative Services		47 MoReg 872	47 MoReg 1723	
5 CSR 30-660.090	Division of Financial and Administrative Services	47 MoReg 779	47 MoReg 784	47 MoReg 1596	
	<b>DEPARTMENT OF HIGHER EDUCATION AND WORKFORCE DEVELOPMENT</b>				
6 CSR 10-2.080	Commissioner of Higher Education		47 MoReg 1579R		
6 CSR 10-2.090	Commissioner of Higher Education		47 MoReg 1579R		
6 CSR 10-2.110	Commissioner of Higher Education		47 MoReg 1767R		
	<b>MISSOURI DEPARTMENT OF TRANSPORTATION</b>				
7 CSR 10-1.020	Missouri Highways and Transportation Commission		47 MoReg 967	47 MoReg 1773	
7 CSR 10-17.020	Missouri Highways and Transportation Commission		47 MoReg 1508		
7 CSR 10-17.030	Missouri Highways and Transportation Commission		47 MoReg 1511		
7 CSR 10-17.040	Missouri Highways and Transportation Commission		47 MoReg 1512		
7 CSR 10-17.050	Missouri Highways and Transportation Commission		47 MoReg 1512		
7 CSR 10-17.060	Missouri Highways and Transportation Commission		47 MoReg 1514		
7 CSR 10-25.010	Missouri Highways and Transportation Commission		47 MoReg 967	47 MoReg 1773	
7 CSR 10-25.020	Missouri Highways and Transportation Commission		47 MoReg 1229		
7 CSR 10-25.030	Missouri Highways and Transportation Commission		47 MoReg 968	47 MoReg 1773	
7 CSR 10-25.070	Missouri Highways and Transportation Commission		47 MoReg 968	47 MoReg 1773	
7 CSR 10-25.071	Missouri Highways and Transportation Commission		47 MoReg 968	47 MoReg 1774	
7 CSR 10-25.080	Missouri Highways and Transportation Commission		47 MoReg 969	47 MoReg 1774	
7 CSR 10-25.090	Missouri Highways and Transportation Commission		47 MoReg 969	47 MoReg 1774	
7 CSR 60-1.010	Highway Safety and Traffic Division		47 MoReg 1515R		
			47 MoReg 1515		
7 CSR 60-1.020	Highway Safety and Traffic Division		47 MoReg 1516R		
			47 MoReg 1516		

# RULE CHANGES SINCE UPDATE

January 3, 2023

Vol. 48, No. 1

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
7 CSR 60-1.030	Highway Safety and Traffic Division		47 MoReg 1517R 47 MoReg 1517		
7 CSR 60-1.040	Highway Safety and Traffic Division		47 MoReg 1518R 47 MoReg 1518		
7 CSR 60-1.050	Highway Safety and Traffic Division		47 MoReg 1519R		
7 CSR 60-1.060	Highway Safety and Traffic Division		47 MoReg 1519R		
7 CSR 60-1.070	Highway Safety and Traffic Division		47 MoReg 1520R		
7 CSR 60-1.080	Highway Safety and Traffic Division		47 MoReg 1520R		
7 CSR 60-1.090	Highway Safety and Traffic Division		47 MoReg 1520R		
7 CSR 60-1.100	Highway Safety and Traffic Division		47 MoReg 1520R		
7 CSR 60-1.110	Highway Safety and Traffic Division		47 MoReg 1521R		
7 CSR 60-2.010	Highway Safety and Traffic Division		47 MoReg 824	47 MoReg 1679	
7 CSR 60-2.020	Highway Safety and Traffic Division		47 MoReg 826	47 MoReg 1679	
7 CSR 60-2.030	Highway Safety and Traffic Division		47 MoReg 826	47 MoReg 1679	
7 CSR 60-2.040	Highway Safety and Traffic Division		47 MoReg 827	47 MoReg 1679	
7 CSR 60-2.050	Highway Safety and Traffic Division		47 MoReg 827	47 MoReg 1680	
7 CSR 60-2.060	Highway Safety and Traffic Division		47 MoReg 828	47 MoReg 1680	
7 CSR 60-3.010	Highway Safety and Traffic Division		47 MoReg 828R 47 MoReg 828	47 MoReg 1680R 47 MoReg 1680	
7 CSR 265-10.017	Motor Carrier and Railroad Safety		47 MoReg 970	47 MoReg 1774	
7 CSR 265-10.025	Motor Carrier and Railroad Safety		47 MoReg 970	47 MoReg 1775	
7 CSR 265-10.035	Motor Carrier and Railroad Safety		47 MoReg 971	47 MoReg 1775	
<b>DEPARTMENT OF MENTAL HEALTH</b>					
9 CSR 10-5.210	Director, Department of Mental Health		47 MoReg 1233	47 MoReg 1775	
9 CSR 30-3.190	Certification Standards		47 MoReg 1432R 47 MoReg 1433		
9 CSR 30-4.0432	Certification Standards		47 MoReg 569	47 MoReg 1455	
9 CSR 30-7.010	Certification Standards		47 MoReg 1768		
9 CSR 45-2.010	Division of Developmental Disabilities		47 MoReg 1580		
9 CSR 45-2.015	Division of Developmental Disabilities		47 MoReg 1585		
9 CSR 45-2.017	Division of Developmental Disabilities		47 MoReg 1587		
9 CSR 45-2.020	Division of Developmental Disabilities		47 MoReg 1591		
<b>DEPARTMENT OF NATURAL RESOURCES</b>					
10 CSR 20-6.010	Clean Water Commission		47 MoReg 1079		
10 CSR 20-6.200	Clean Water Commission		47 MoReg 1081		
10 CSR 90-2.010	State Parks		47 MoReg 1289		
10 CSR 90-2.030	State Parks		47 MoReg 1290		
10 CSR 90-2.050	State Parks		47 MoReg 1291		
10 CSR 140-2	Division of Energy				47 MoReg 1459
10 CSR 140-8.010	Division of Energy		47 MoReg 1082	47 MoReg 1723W	
<b>DEPARTMENT OF PUBLIC SAFETY</b>					
11 CSR 45-7.010	Missouri Gaming Commission		47 MoReg 1711		
11 CSR 45-7.120	Missouri Gaming Commission		47 MoReg 1711		
11 CSR 45-7.145	Missouri Gaming Commission		47 MoReg 1712		
11 CSR 45-9.030	Missouri Gaming Commission		47 MoReg 1436		
11 CSR 45-9.104	Missouri Gaming Commission		47 MoReg 1436		
11 CSR 45-9.109	Missouri Gaming Commission		47 MoReg 1437		
11 CSR 45-9.112	Missouri Gaming Commission		47 MoReg 1592		
11 CSR 70-2.120	Division of Alcohol and Tobacco Control		47 MoReg 874	47 MoReg 1724	
11 CSR 70-2.130	Division of Alcohol and Tobacco Control		47 MoReg 875	47 MoReg 1724	
11 CSR 70-2.140	Division of Alcohol and Tobacco Control		47 MoReg 877	47 MoReg 1725	
11 CSR 70-2.150	Division of Alcohol and Tobacco Control		47 MoReg 879	47 MoReg 1726	
11 CSR 70-2.190	Division of Alcohol and Tobacco Control		47 MoReg 879	47 MoReg 1726	
11 CSR 70-2.280	Division of Alcohol and Tobacco Control		47 MoReg 881	47 MoReg 1727	
<b>DEPARTMENT OF REVENUE</b>					
12 CSR 10-41.010	Director of Revenue	47 MoReg 1703	47 MoReg 1712		
<b>DEPARTMENT OF SOCIAL SERVICES</b>					
13 CSR 35-31.100	Children's Division		47 MoReg 1772		
13 CSR 40-37.010	Family Support Division		47 MoReg 1437R		
13 CSR 70-3.030	MO HealthNet Division		47 MoReg 1291		
13 CSR 70-3.180	MO HealthNet Division		46 MoReg 1675 47 MoReg 237		
13 CSR 70-3.320	MO HealthNet Division		47 MoReg 883	47 MoReg 1546	
13 CSR 70-4.051	MO HealthNet Division		47 MoReg 886R	47 MoReg 1546 R	
13 CSR 70-5.010	MO HealthNet Division		47 MoReg 886	47 MoReg 1547	
13 CSR 70-8.010	MO HealthNet Division		47 MoReg 1298		
13 CSR 70-15.010	MO HealthNet Division	47 MoReg 927	47 MoReg 973	47 MoReg 1775	
13 CSR 70-15.015	MO HealthNet Division	47 MoReg 944	47 MoReg 990	47 MoReg 1727	
13 CSR 70-15.110	MO HealthNet Division	47 MoReg 950	47 MoReg 996	47 MoReg 1728	
13 CSR 70-15.160	MO HealthNet Division	47 MoReg 956	47 MoReg 1002	47 MoReg 1730	
13 CSR 70-15.190	MO HealthNet Division	47 MoReg 1061	47 MoReg 1083	47 MoReg 1731	
13 CSR 70-15.220	MO HealthNet Division	47 MoReg 1062	47 MoReg 1085	47 MoReg 1784	
13 CSR 70-15.230	MO HealthNet Division	47 MoReg 960	47 MoReg 1006	47 MoReg 1731	
13 CSR 70-20.042	MO HealthNet Division		47 MoReg 1437	47 MoReg 1786W	
13 CSR 70-90.010	MO HealthNet Division		47 MoReg 1716		
13 CSR 70-95.010	MO HealthNet Division		47 MoReg 1299		
13 CSR 70-97.010	MO HealthNet Division		47 MoReg 1716		
13 CSR 70-98.030	MO HealthNet Division		47 MoReg 1438		
13 CSR 110-5.010	Division of Youth Services		47 MoReg 1772		

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
<b>ELECTED OFFICIALS</b>					
15 CSR 30-14.010	Secretary of State		47 MoReg 886	47 MoReg 1455	
15 CSR 30-200.015	Secretary of State		47 MoReg 1677		
<b>RETIREMENT SYSTEMS</b>					
16 CSR 10-5.010	The Public School Retirement System of Missouri		47 MoReg 1300	47 MoReg 1786	
16 CSR 10-5.020	The Public School Retirement System of Missouri		47 MoReg 829	47 MoReg 1455	
16 CSR 10-6.060	The Public School Retirement System of Missouri		47 MoReg 1301	47 MoReg 1786	
16 CSR 10-6.070	The Public School Retirement System of Missouri		47 MoReg 832	47 MoReg 1455	
16 CSR 50-1.010	The County Employees' Retirement Fund		47 MoReg 1677		
<b>DEPARTMENT OF HEALTH AND SENIOR SERVICES</b>					
19 CSR 10-15.010	Office of the Director		47 MoReg 1593		
19 CSR 20-20.020	Division of Community and Public Health	47 MoReg 1369	47 MoReg 1371		
19 CSR 20-60.010	Division of Community and Public Health		47 MoReg 1521		
19 CSR 25-30.021	Missouri State Public Health Laboratory	47 MoReg 1706	47 MoReg 1718		
19 CSR 30-1.002	Division of Regulation and Licensure	47 MoReg 1481	47 MoReg 1522		
19 CSR 30-1.015	Division of Regulation and Licensure		47 MoReg 1375	This Issue	
19 CSR 30-1.017	Division of Regulation and Licensure		47 MoReg 1378	This Issue	
19 CSR 30-20.144	Division of Regulation and Licensure	47 MoReg 1495	47 MoReg 1532		
19 CSR 30-35.010	Division of Regulation and Licensure		47 MoReg 1538		
19 CSR 30-40.410	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.420	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.430	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.710	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.720	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.730	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.740	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.750	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.760	Division of Regulation and Licensure	This Issue	This Issue		
19 CSR 30-40.792	Division of Regulation and Licensure		This Issue		
19 CSR 30-100.010	Division of Regulation and Licensure	47 MoReg 1265	47 MoReg 1305	47 MoReg 1786	
19 CSR 60-50	Missouri Health Facilities Review Committee				47 MoReg 1549 47 MoReg 1597 47 MoReg 1801 This Issue
19 CSR 60-50.300	Missouri Health Facilities Review Committee		47 MoReg 1097	47 MoReg 1732	
19 CSR 60-50.400	Missouri Health Facilities Review Committee		47 MoReg 1100	47 MoReg 1732	
19 CSR 60-50.410	Missouri Health Facilities Review Committee		47 MoReg 1106	47 MoReg 1733	
19 CSR 60-50.420	Missouri Health Facilities Review Committee		47 MoReg 1110	47 MoReg 1736	
19 CSR 60-50.430	Missouri Health Facilities Review Committee		47 MoReg 1110	47 MoReg 1736	
19 CSR 60-50.440	Missouri Health Facilities Review Committee		47 MoReg 1122	47 MoReg 1741	
19 CSR 60-50.450	Missouri Health Facilities Review Committee		47 MoReg 1122	47 MoReg 1741	
19 CSR 60-50.470	Missouri Health Facilities Review Committee		47 MoReg 1125	47 MoReg 1741	
19 CSR 60-50.500	Missouri Health Facilities Review Committee		47 MoReg 1128	47 MoReg 1741	
19 CSR 60-50.700	Missouri Health Facilities Review Committee		47 MoReg 1128	47 MoReg 1742	
19 CSR 60-50.800	Missouri Health Facilities Review Committee		47 MoReg 1137	47 MoReg 1742	
19 CSR 73-2.130	Missouri Board of Nursing Home Administrators		This Issue		
<b>DEPARTMENT OF COMMERCE AND INSURANCE</b>					
20 CSR	Applied Behavior Analysis Maximum Benefit				47 MoReg 385
20 CSR	Construction Claims Binding Arbitration Cap				47 MoReg 43
20 CSR	Non-Economic Damages in Medical Malpractice Cap				47 MoReg 385
20 CSR	Sovereign Immunity Limits				47 MoReg 1801
20 CSR	State Legal Expense Fund Cap				47 MoReg 43
20 CSR 500-4.300	Property and Casualty		47 MoReg 1381		
20 CSR 2010-2.065	Missouri State Board of Accountancy		47 MoReg 1233	47 MoReg 1742	
20 CSR 2010-2.085	Missouri State Board of Accountancy		This Issue		
20 CSR 2010-2.160	Missouri State Board of Accountancy		This Issue		
20 CSR 2010-3.060	Missouri State Board of Accountancy		This Issue		
20 CSR 2010-4.031	Missouri State Board of Accountancy		This Issue		
20 CSR 2010-4.035	Missouri State Board of Accountancy		This Issue		
20 CSR 2030-5.110	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 1718		
20 CSR 2030-5.120	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 1719		
20 CSR 2030-5.130	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 1719		
20 CSR 2030-6.015	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 1720		
20 CSR 2030-14.020	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 1720		
20 CSR 2030-14.030	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 1721		
20 CSR 2030-14.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Professional Landscape Architects		47 MoReg 1721		
20 CSR 2095-1.020	Committee for Professional Counselors		47 MoReg 1544		

# RULE CHANGES SINCE UPDATE

January 3, 2023  
Vol. 48, No. 1

RULE NUMBER	AGENCY	EMERGENCY	PROPOSED	ORDER	IN ADDITION
20 CSR 2063-2.005	Behavior Analyst Advisory Board		47 MoReg 1594		
20 CSR 2063-2.010	Behavior Analyst Advisory Board		47 MoReg 1594		
20 CSR 2110-2.050	Missouri Dental Board		47 MoReg 887	47 MoReg 1547	
20 CSR 2120-1.040	State Board of Embalmers and Funeral Directors		47 MoReg 1443		
20 CSR 2120-2.010	State Board of Embalmers and Funeral Directors		47 MoReg 1443		
20 CSR 2120-2.060	State Board of Embalmers and Funeral Directors		47 MoReg 1445		
20 CSR 2145-2.065	Missouri Board of Geologist Registration		47 MoReg 1595R		
20 CSR 2150-2.080	State Board of Registration for the Healing Arts	This Issue	This Issue		
20 CSR 2150-5.024	State Board of Registration for the Healing Arts		47 MoReg 1381	This Issue	
20 CSR 2150-7.200	State Board of Registration for the Healing Arts	This Issue	This Issue		
20 CSR 2165-2.010	Board of Examiners for Hearing Instrument Specialists		47 MoReg 887	47 MoReg 1547	
20 CSR 2165-2.025	Board of Examiners for Hearing Instrument Specialists		47 MoReg 888	47 MoReg 1547	
20 CSR 2165-2.040	Board of Examiners for Hearing Instrument Specialists		47 MoReg 889R	47 MoReg 1547R	
20 CSR 2165-2.060	Board of Examiners for Hearing Instrument Specialists		47 MoReg 889	47 MoReg 1547	
20 CSR 2220-2.400	State Board of Pharmacy	47 MoReg 965			
20 CSR 2220-2.685	State Board of Pharmacy		47 MoReg 835	47 MoReg 1548	
20 CSR 2220-6.025	State Board of Pharmacy		47 MoReg 1383	This Issue	
20 CSR 2220-7.010	State Board of Pharmacy		47 MoReg 890	47 MoReg 1548	
20 CSR 2220-7.030	State Board of Pharmacy		47 MoReg 891	47 MoReg 1548	
20 CSR 2230-2.010	State Board of Podiatric Medicine		47 MoReg 1139	47 MoReg 1680	
20 CSR 2231-1.010	Division of Professional Registration		47 MoReg 835	47 MoReg 1456	
20 CSR 2231-2.010	Division of Professional Registration		47 MoReg 835	47 MoReg 1456	
20 CSR 2233-2.010	State Committee of Marital and Family Therapists		47 MoReg 1139	47 MoReg 1680	
20 CSR 2234-5.010	Board of Private Investigator and Private Fire Investigator Examiners		47 MoReg 892	47 MoReg 1548	
20 CSR 2245-2.020	Real Estate Appraisers		47 MoReg 1448		
20 CSR 2245-2.030	Real Estate Appraisers		47 MoReg 1448		
20 CSR 2245-3.010	Real Estate Appraisers		47 MoReg 1449		
20 CSR 2245-6.016	Real Estate Appraisers		47 MoReg 1450R		
20 CSR 2245-6.040	Real Estate Appraisers		47 MoReg 1450R		
20 CSR 2245-7.060	Real Estate Appraisers		47 MoReg 1450		
20 CSR 2245-8.020	Real Estate Appraisers		47 MoReg 1451		
20 CSR 2245-8.050	Real Estate Appraisers		47 MoReg 1451		
20 CSR 2263-2.031	State Committee for Social Workers		47 MoReg 892	47 MoReg 1548	
20 CSR 2267-2.020	Office of Tattooing, Body Piercing, and Branding		47 MoReg 1451		
20 CSR 2267-2.034	Office of Tattooing, Body Piercing, and Branding		47 MoReg 1233R	47 MoReg 1742R	
20 CSR 4240-40.020	Public Service Commission		47 MoReg 1316		
20 CSR 4240-40.030	Public Service Commission		47 MoReg 1318		
<b>MISSOURI CONSOLIDATED HEALTH CARE PLAN</b>					
22 CSR 10-2.089	Health Care Plan	47 MoReg 1706	47 MoReg 1722		

# EMERGENCY RULE TABLE

AGENCY	PUBLICATION	EFFECTIVE	EXPIRATION
--------	-------------	-----------	------------

## Department of Elementary and Secondary Education

### Division of Learning Services

5 CSR 20-400.220	Application for Substitute Certificate of License to Teach	.47 MoReg 1419	Sept. 14, 2022	March 12, 2023
------------------	--	----------------	----------------	----------------

### Divisional of Financial and Administrative Services

5 CSR 30-660.090	Charter School Local Education Agency (LEA) Attendance Hour Reporting	.47 MoReg 779	May 3, 2022	Feb. 9, 2023
------------------	---	---------------	-------------	--------------

## Department of Revenue

### Director of Revenue

12 CSR 10-41.010	Annual Adjusted Rate of Interest	.47 MoReg 1703	Jan. 1, 2023	June 29, 2023
------------------	----------------------------------	----------------	--------------	---------------

## Department of Social Services

### MO HealthNet Division

13 CSR 70-15.010	Inpatient Hospital Services Reimbursement Methodology	.47 MoReg 927	July 1, 2022	Feb. 23, 2023
13 CSR 70-15.015	Direct Medicaid Payments	.47 MoReg 944	July 1, 2022	Feb. 23, 2023
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	.47 MoReg 950	July 1, 2022	Feb. 23, 2023
13 CSR 70-15.160	Outpatient Hospital Services Reimbursement Methodology	.47 MoReg 956	July 1, 2022	Feb. 23, 2023
13 CSR 70-15.190	Out-of-State Hospital Services Reimbursement Plan	.47 MoReg 1061	July 1, 2022	Feb. 23, 2023
13 CSR 70-15.220	Disproportionate Share Hospital (DSH) Payments	.47 MoReg 1062	July 1, 2022	Feb. 23, 2023
13 CSR 70-15.230	Upper Payment Limit (UPL) Payment Methodology	.47 MoReg 960	July 1, 2022	Feb. 23, 2023

## Department of Health and Senior Services

### Division of Community and Public Health

19 CSR 20-20.020	Reporting Infectious, Contagious, Communicable, or Dangerous Diseases	.47 MoReg 1369	Aug. 29, 2022	Feb. 24, 2023
------------------	---	----------------	---------------	---------------

### Missouri State Public Health Laboratory

19 CSR 25-30.021	Type I Permit	.47 MoReg 1706	Nov. 16, 2022	May 14, 2023
------------------	---------------	----------------	---------------	--------------

### Division of Regulation and Licensure

19 CSR 30-1.002	Schedules of Controlled Substances	.47 MoReg 1481	Oct. 3, 2022	March 31, 2023
19 CSR 30-20.144	Standards and Guidelines for Essential Caregiver Program	.47 MoReg 1495	Sept. 29, 2022	March 27, 2023
19 CSR 30-40.410	Definitions and Abbreviations Relating to Trauma Centers	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-40.420	Trauma Center Designation Requirements	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-40.430	Standards for Trauma Center Designation	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-40.710	Definitions and Abbreviations Relating to Stroke Centers	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-40.720	Stroke Center Designation Application and Review	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-40.730	Standards for Stroke Center Designation	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-40.740	Definitions and Abbreviations Relating to ST-Segment Elevation Myocardial Infarction (STEMI) Centers	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-40.750	ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-40.760	Standards for ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation	This Issue	Dec. 7, 2022	June 4, 2023
19 CSR 30-100.010	Newborn Safety Incubators	.47 MoReg 1265	Aug. 12, 2022	Feb. 23, 2023

## Department of Commerce and Insurance

### State Board of Registration for the Healing Arts

20 CSR 2150-2.080	Physician Licensure Fees	This Issue	Jan. 1, 2023	June 29, 2023
20 CSR 2150-7.200	Physician Assistant Licensure Fees	This Issue	Jan. 1, 2023	June 29, 2023

## Missouri Consolidated Health Care Plan

### Health Care Plan

22 CSR 10-2.089	Pharmacy Employer Group Waiver Plan for Medicare Primary Members	.47 MoReg 1706	Jan. 1, 2023	June 29, 2023
-----------------	--	----------------	--------------	---------------

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo.

ORDER	SUBJECT MATTER	FILED DATE	PUBLICATION
<b>2022</b>			
<b>22-08</b>	Declares a State of Emergency and waives certain regulations to allow other registered entities to fill liquefied petroleum gas containers owned by Gygr-Gas.	December 15, 2022	Next Issue
<b>22-07</b>	Extends Executive Order 22-04 to address drought-response efforts until March 1, 2023.	November 28, 2022	This Issue
<b>22-06</b>	Closes executive branch state offices for Friday, November 25, 2022.	November 7, 2022	47 MoReg 1708
<b>Proclamation</b>	Convenes the One Hundred First General Assembly in the First Extraordinary Session of the Second Regular Session regarding extension of agricultural tax credits and to enact legislation amending Missouri income tax.	August 22, 2022	47 MoReg 1420
<b>22-05</b>	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to severe storm systems.	July 26, 2022	47 MoReg 1279
<b>22-04</b>	Declares a drought alert for 53 Missouri counties and orders the director of the Department of Natural Resources to activate and designate a chairperson for the Drought Assessment Committee.	July 21, 2022	47 MoReg 1277
<b>Proclamation</b>	In accordance with <i>Dobbs</i> , Section 188.017, RSMo is hereby effective as of the date of this order.	June 24, 2022	47 MoReg 1075
<b>22-03</b>	Terminates the State of Emergency declared in Executive Order 22-02.	February 7, 2022	47 MoReg 411
<b>22-02</b>	Declares a State of Emergency and directs the Missouri State Emergency Operations Plan be activated due to forecasted severe winter storm systems.	February 1, 2022	47 MoReg 304
<b>22-01</b>	Establishes and Designates the Missouri Early Childhood State Advisory Council.	January 7, 2022	47 MoReg 222

The rule number and the MoReg publication date follow each entry to this index.

**ADMINISTRATION, OFFICE OF**

information, submissions or requests; 1 CSR 15-1.207; 12/15/22  
preapproval of claims/accounts and direct deposit:  
definitions/examples; 1 CSR 10-3.010; 1/3/23  
state official's salary compensation schedule; 1 CSR 10; 10/3/22

**AGRICULTURE, DEPARTMENT OF**

state milk board

inspection fees; 2 CSR 80-5.010; 7/15/22, 11/1/22  
state milk board grade "A" milk policies; 2 CSR 80-2.190;  
7/15/22, 11/1/22

weights, measures and consumer protection

NFPA manual no.54, *national fuel gas code*; 2 CSR 90-10.020;  
10/3/22  
registration of servicepersons and service agencies; 2 CSR  
90-21.010; 1/3/23

**CONSERVATION, DEPARTMENT OF**

closings; 3 CSR 10-11.15; 9/1/22  
deer: firearms hunting season; 3 CSR 10-7.433; 7/1/22, 10/17/22  
dove hunting; 3 CSR 10-11.185; 9/1/22  
elk: hunting season; 3 CSR 10-7.705; 5/2/22, 7/1/22, 10/17/22  
fishing, daily and possession limits; 3 CSR 10-12.140; 9/1/22  
fishing, length limits;  
3 CSR 10-11.215; 9/1/22  
3 CSR 10-12.145; 9/1/22  
fishing, methods; 3 CSR 10-12.135; 9/1/22  
licensed hunting preserve: privileges; 3 CSR 10-9.565; 10/17/22  
privileges of class III wildlife breeders; 3 CSR 10-9.354; 10/17/22  
quail hunting; 3 CSR 10-11.184; 9/1/22  
resident black bear hunting permit; 3 CSR 10-5.900; 10/3/22  
use of boats and motors;  
3 CSR 10-11.160; 10/17/22  
3 CSR 10-12.110; 9/1/22

**CREDIT AND FINANCE**

**ECONOMIC DEVELOPMENT, DEPARTMENT OF**

businesses and activities ineligible for capital access program  
assistance; 4 CSR 80-6.010; 12/1/22  
complaints; 4 CSR 85-3.040; 12/1/22  
designation; 4 CSR 85-3.030; 12/1/22  
enterprise zone program; 4 CSR 85-3.010; 12/1/22  
general organization;  
4 CSR 85-1.010; 12/1/22  
4 CSR 260-1.010; 12/1/22  
the application process; 4 CSR 85-3.020; 12/1/22  
withdrawal of approval; 4 CSR 85-3.050; 12/1/22

**ELECTED OFFICIALS**

secretary of state

campaign contribution limits; 15 CSR 30-14.010; 7/1/22,  
10/3/22  
library certification requirement for the protection of  
minors; 15 CSR 30-200.015; 11/15/22

**ELEMENTARY AND SECONDARY EDUCATION,  
DEPARTMENT OF**

division of financial and administrative services

attendance hour reporting; 5 CSR 30-660.085; 9/15/22  
audit policy and requirements; 5 CSR 30-4.030; 7/1/22,  
12/1/22  
charter school local education agency (LEA) attendance  
hour reporting; 5 CSR 30-660.090; 6/1/22, 11/1/22

division of learning services

application for substitute certificate of license to teach;  
5 CSR 20-400.220; 10/3/22  
certification requirements for initial administration  
certificate; 5 CSR 20-400.610; 8/1/22, 1/3/23  
Missouri career development and teacher excellence plan;  
5 CSR 20-400.370; 10/3/22

training; 5 CSR 20-500.250; 6/1/22, 11/1/22  
office of childhood  
eligibility and authority for child care subsidy;  
5 CSR 25-200.060; 10/3/22  
general provisions governing programs authorized under  
the early childhood development act; 5 CSR 25-100.330;  
8/1/22, 1/3/23  
individuals with disabilities education act, part c;  
5 CSR 25-100.120; 11/1/22  
personnel; 5 CSR 25-500.102; 11/1/22  
the child care provider and other child care personnel;  
5 CSR 25-400.105; 11/1/22

**EXECUTIVE ORDERS**

convenes the first extra session of the second regular session  
of the one hundredth first general assembly regarding  
extension of agricultural tax credits and to enact legislation  
amending Missouri income tax; Proclamation; 10/3/22  
closes executive branch state offices for Friday, November 25,  
2022; 22-06; 12/1/22  
extends Executive Order 22-04 to address drought-response  
efforts until March 1, 2023; 22-07; 1/3/23

**HEALTH AND SENIOR SERVICES, DEPARTMENT OF**

community and public health, division of

levels of maternal and neonatal care designations;  
19 CSR 20-60.010; 10/17/22  
reporting infectious, contagious, communicable, or  
dangerous diseases; 19 CSR 20-20.020; 9/15/22  
Missouri health facilities review committee  
additional information; 19 CSR 60-50.500; 8/1/22, 12/1/22  
application package; 19 CSR 60-50.430; 8/1/22, 12/1/22  
criteria and standards for equipment and new hospitals;  
19 CSR 60-50.440; 8/1/22, 12/1/22  
criteria and standards for financial feasibility;  
19 CSR 60-50.470; 8/1/22, 12/1/22  
criteria and standards for long-term care; 19 CSR 60-50.450;  
8/1/22, 12/1/22  
definitions for the certificate of need process;  
19 CSR 60-050.300; 8/1/22, 12/1/22  
letter of intent package; 19 CSR 60-50.410; 8/1/22, 12/1/22  
letter of intent process; 19 CSR 60-50.400; 8/1/22, 12/1/22  
meeting procedures; 19 CSR 60-500.800; 8/1/22, 12/1/22  
Missouri health facilities review committee; 19 CSR 60-050;  
10/3/22, 11/1/22, 12/15/22, 1/3/23  
post-decision activity; 19 CSR 60-50.700; 8/1/22, 12/1/22  
review process; 19 CSR 60-50.420; 8/1/22, 12/1/22

Missouri state public health laboratory

type I permit; 19 CSR 25-30.021; 12/1/22  
nursing home administrators, Missouri board of  
notice of change of [address] contact information and  
Missouri administrator employment; 19 CSR 73-2.130;  
1/3/23

office of the director

[report of induced termination of pregnancy] abortion  
report; 19 CSR 10-15.010; 11/1/22

regulation and licensure, division of

adult trauma and pediatric field triage and transport;  
19 CSR 30-40.792; 1/3/23  
definitions and abbreviations relating to st-segment;  
19 CSR 30-40.740; 1/3/23  
definitions and abbreviations relating to stroke centers;  
19 CSR 30-40.710; 1/3/23  
definitions and abbreviations relating to trauma centers;  
19 CSR 30-40.410; 1/3/23  
hospice program operations; 19 CSR 30-35.010; 10/17/22  
newborn safety incubators; 19 CSR 30-100.010; 9/1/22,  
12/15/22  
registration and fees; 19 CSR 30-1.015; 9/15/22, 1/3/23  
registration process; 19 CSR 30-1.017; 9/15/22, 1/3/23  
schedules of controlled substances; 19 CSR 30-1.002; 10/17/22

standards and guidelines for essential caregiver program;  
19 CSR 30-20.144; 10/17/22  
standards for st-segment elevation myocardial infarction  
(STEMI) center designation; 19 CSR 30-40.760; 1/3/23  
standards for stroke center designation; 19 CSR 30-40.730;  
1/3/23  
standards for trauma center designation; 19 CSR 30-40.430;  
1/3/23  
st-segment elevation myocardial infarction (STEMI) center  
designation application and review; 19 CSR 30-40.750;  
1/3/23  
stroke center designation application and review; 19 CSR  
30-40.720; 1/3/23  
trauma center designation requirements; 19 CSR 30-40.420;  
1/3/23

#### **HIGHER EDUCATION AND WORKFORCE DEVELOPMENT, DEPARTMENT OF**

guarantors of student loans to missourians; 6 CSR 10-2.090;  
11/1/22  
higher education academic scholarship program;  
6 CSR 10-2.080; 11/1/22  
wage garnishment for repayment of defaulted guaranteed  
student loans; 6 CSR 10-2.110; 12/15/22

#### **INSURANCE**

applied behavior analysis maximum benefit; 20 CSR; 3/1/22  
construction claims binding arbitration cap; 20 CSR; 1/3/22  
non-economic damages in medical malpractice cap;  
20 CSR; 3/1/22  
sovereign immunity limits; 20 CSR; 1/3/22  
state legal expense fund; 20 CSR; 1/3/22  
property and casualty  
rate variations (consent rate) prerequisites;  
20 CSR 500-4.300; 9/15/22

#### **LABOR AND INDUSTRIAL RELATIONS, DEPARTMENT OF**

#### **MENTAL HEALTH, DEPARTMENT OF**

##### certification standards

assertive community treatment (ACT) in community  
psychiatric rehabilitation programs; 9 CSR 30-4.0432;  
4/15/22, 10/3/22  
behavioral health crisis centers; 9 CSR 30-7.010; 12/15/22  
comprehensive substance treatment and rehabilitation  
(CSTAR) program for women and children; 9 CSR 30-3.190;  
10/3/22  
specialized program for women and children;  
9 CSR 30-3.190; 10/3/22

##### developmental disabilities, division of

appeals procedures for service eligibility through the  
division of developmental disabilities; 9 CSR 45-2.020;  
11/1/22  
eligibility for services from the division of developmental  
disabilities; 9 CSR 45-2.010; 11/1/22  
prioritizing access to funded services; 9 CSR 45-2.015; 11/1/22  
utilization review process; 9 CSR 45-2.017; 11/1/22

##### director, department of mental health

exceptions committee procedures; 9 CSR 10-5.210; 8/15/22,  
12/15/22

#### **MISSOURI CONSOLIDATED HEALTH CARE PLAN**

pharmacy employer group waiver plan for medicare primary  
members; 22 CSR 10-2.089; 12/1/22

#### **NATURAL RESOURCES, DEPARTMENT OF**

##### air conservation commission

construction and operating permits; 10 CSR 20-6.010; 8/1/22  
storm water regulations; 10 CSR 20-6.200; 8/1/22

##### energy, division of

certification of renewable energy and renewable energy  
standard compliance account; 10 CSR 140-8.010; 8/1/22,  
12/1/22  
energy efficiency and renewable energy loan cycle;  
10 CSR 140-2; 10/3/22

##### state parks

camping and recreational activities; 10 CSR 90-2.030; 9/1/22  
definitions; 10 CSR 90-2.010; 9/1/22  
organized group camps; 10 CSR 90-2.050; 9/1/22

#### **PROFESSIONAL REGISTRATION**

##### accountancy, missouri state board of

continuing professional education (CPE) documentation;  
20 CSR 2010-4.031; 1/3/23  
fees; 20 CSR 2010-2.160, 1/3/23  
inactive, expired, and lapsed licenses; 20 CSR 2010-4.035;  
1/3/23  
other responsibilities and practices; 20 CSR 2010-3.060;  
1/3/23  
reinstatement of firm permit; 20 CSR 2010-2.085; 1/3/23  
requirements for licensure through reciprocity;  
20 CSR 2010-2.065; 8/15/22, 12/1/22

##### behavior analyst advisory board

application for licensure; 20 CSR 2063-2.005; 11/1/22  
renewal of license, inactive license, and reactivation of  
license; 20 CSR 2063-2.010; 11/1/22

##### cosmetology and barber examiners, board of dental board, missouri

licensure by examination – dental hygienists;  
20 CSR 2110-2.050; 7/1/22, 10/17/22

##### embalmers and funeral directors, state board of

definitions; 20 CSR 2120-1.040; 10/3/22  
embalmer's registration and apprenticeship;  
20 CSR 2120-2.010; 10/3/22

funeral directing; 20 CSR 2120-2.060; 10/3/22

##### examiners for hearing instrument specialists, board of

application procedures; 20 CSR 2165-2.025; 7/1/22, 10/17/22  
hearing instrument specialist in training (temporary  
permits); 20 CSR 2165-2.010; 7/1/22, 10/17/22  
license renewal; 20 CSR 2165-2.060; 7/1/22, 10/17/22  
licensure by reciprocity; 20 CSR 2165-2.040; 7/1/22, 10/17/22

##### geologist registration, missouri board of

temporary courtesy license; 20 CSR 2145-2.065; 11/1/22

##### marital and family therapists, state committee of

educational requirements; 20 CSR 2233-2.010; 8/1/22, 11/15/22

##### Missouri board for architects, professional engineers, professional land surveyors, and professional landscape architects

application, renewal, relicensure, and miscellaneous fees;  
20 CSR 2030-6.015; 12/1/22

definition of baccalaureate degree from approved  
curriculum as used in section 327.312.1(1), RSMo; 12/1/22  
definition of twelve semester hours of approved surveying  
course work as used in section 327.312.1(3), RSMo;  
20 CSR 2030-14.040; 12/1/22

definition of twenty semester hours of approved surveying  
course work as used in section 327.312.1(2), RSMo;  
20 CSR 2030-14.030; 12/1/22

reexamination – land [surveyor-in-training] *surveyor-  
intern* and professional land surveyor; 20 CSR 2030-5.130;  
12/1/22

scope of examination – land [surveyor-in-training] *surveyor-  
intern* and professional land surveyors; 20 CSR 2030-5.120;  
12/1/22

standards for admission to examination – professional land  
surveyors; 20 CSR 2030-5.110; 12/1/22

##### optometry, state board

##### pharmacy, state board of

compounding standards of practice; 20 CSR 2220-2.400;  
7/15/22

general licensing rules; 20 CSR 2220-7.010; 7/1/22, 10/17/22  
HIV post-exposure prophylaxis; 20 CSR 2220-6.025; 9/15/22,  
1/3/23

pharmacist licensure by examination; 20 CSR 2220-7.030;  
7/1/22, 10/17/22

standards of operation for a class Q: charitable pharmacy;  
20 CSR 2220-2.685; 6/15/22, 10/17/22

##### podiatric medicine, state board of

licensure by examination; 20 CSR 2230-2.010; 8/1/22, 11/15/22

private investigator and private fire investigator examiners, board of

examination; 20 CSR 2234-5.010; 7/1/22, 10/17/22  
professional counselors, committee for  
fees; 20 CSR 2095-1.020; 10/17/22  
professional registration, division of  
designation of license renewal dates and related renewal information; 20 CSR 2231-2.010; 6/15/22, 10/3/22  
general organization; 20 CSR 2231-1.010; 6/15/22, 10/3/22  
real estate appraisers  
applications for certification and licensure; 20 CSR 2245-3.010; 10/3/22  
case study courses; 20 CSR 2245-6.040; 10/3/22  
commission action; 20 CSR 2245-2.020; 10/3/22  
course approval; 20 CSR 2245-8.020; 10/3/22  
examinations and education; 20 CSR 2245-6.016; 10/3/22  
investigation and review; 20 CSR 2245-7.060; 10/3/22  
20 CSR 2245-8.050; 10/3/22  
records; 20 CSR 2245-2.030; 10/3/22  
registration for the healing arts, state board of  
HIV post-exposure prophylaxis; 20 CSR 2150-5.024; 9/15/22, 1/3/23  
physician assistant licensure fees; 20 CSR 2150-7.200; 1/3/23  
physician licensure fees; 20 CSR 2150-2.080; 1/3/23  
social workers, state committee for  
acceptable supervisors and supervisor responsibilities; 20 CSR 2263-2.031; 7/1/22, 10/17/22  
tattooing, body piercing, and branding, office of  
fees; 20 CSR 2267-2.020; 10/3/22  
issuance of temporary courtesy license to nonresident military spouse; 20 CSR 2267-2.034; 8/15/22, 12/1/22

**PUBLIC SAFETY, DEPARTMENT OF**

alcohol and tobacco control, division of  
all licensees; 11 CSR 70-2.140; 7/1/22, 12/1/22  
retail licensees; 11 CSR 70-2.120; 7/1/22, 12/1/22  
retailer's conduct of business; 11 CSR 70-2.130; 7/1/22, 12/1/22  
standards for using minors in intoxicating liquor investigations; 11 CSR 70-2.280; 7/1/22, 12/1/22  
tax credit and refunds; 11 CSR 70-2.150; 7/1/22, 12/1/22  
unlawful discrimination and price scheduling; 11 CSR 70-2.190; 7/1/22, 12/1/22

Missouri gaming commission

definition of licensee; 11 CSR 45-7.010; 12/1/22  
minimum internal control standards; 11 CSR 45-9.030; 10/3/22  
minimum internal control standards (MICS) – chapter I; 11 CSR 45-9.109; 10/3/22  
minimum internal control standards (MICS) – chapter L; 11 CSR 45-9.112; 11/1/22  
reimbursement for cost of *contracted* commission agents; 11 CSR 45-7.145; 12/1/22  
surveillance system plans; 11 CSR 45-7.120; 12/1/22

**PUBLIC SERVICE COMMISSION**

incident, annual, and safety-related condition reporting requirements; 20 CSR 4240-40.020; 9/1/22  
safety standards – transportation of gas by pipeline; 20 CSR 4240-40.030; 9/1/22

**RETIREMENT SYSTEMS**

disability retirement; 16 CSR 10-5.020; 6/15/22, 10/3/22  
16 CSR 10-6.070; 6/15/22, 10/3/22  
general organization; 16 CSR 50-1.010; 11/15/22  
service retirement; 16 CSR 10-5.010; 9/1/22, 12/15/22  
16 CSR 10-6.060; 9/1/22, 12/15/22

**REVENUE, DEPARTMENT OF**

annual adjusted rate of interest; 12 CSR 10-14.010; 12/1/22

**SOCIAL SERVICES, DEPARTMENT OF**  
children's division

use and dissemination of information from the central registry; 13 CSR 35-31.100; 12/15/22  
family support division  
basis for provision; 13 CSR 40-37.010; 10/3/22  
mo healthnet division  
applied behavior analysis services; 13 CSR 70-98.030; 10/3/22  
automatic refill programs and medication synchronization programs; 13 CSR 70-20.042; 10/3/22, 12/15/22  
copayment for pharmacy services; 13 CSR 70-4.051; 7/1/22, 10/17/22  
direct medicaid payments; 13 CSR 70-15.015; 7/15/22, 12/1/22  
disproportionate share hospital (DSH) payments; 13 CSR 70-15.220; 8/1/22, 12/15/22  
electronic visit verification (EVV); 13 CSR 70-3.320; 7/1/22, 10/17/22  
federal reimbursement allowance (FRA); 13 CSR 70-15.110; 7/15/22, 12/1/22  
health insurance premium payment (HIPPI) program; 13 CSR 70-97.010; 12/1/22  
home health-care services; 13 CSR 70-90.010; 12/1/22  
inpatient hospital services reimbursement methodology; 13 CSR 70-15.010; 7/15/22, 12/15/22  
nonemergency medical transportation (NEMT) services; 13 CSR 70-5.010; 7/1/22, 10/17/22  
out-of-state hospital services reimbursement plan; 13 CSR 70-15.190; 8/1/22, 12/1/22  
outpatient hospital services reimbursement methodology; 13 CSR 70-15.160; 7/15/22, 12/1/22  
private duty nursing; 13 CSR 70-95.010; 9/1/22  
program of all-inclusive care for the elderly; 13 CSR 70-8.010; 9/1/22  
[sanctions] administrative actions for improperly paid, false, or fraudulent claims for mo healthnet services; 13 CSR 70-3.030; 9/1/22  
upper payment limit (UPL) payment methodology; 13 CSR 70-15.230; 7/15/22, 12/1/22  
youth services, division of  
dual jurisdiction procedures; 13 CSR 110-5.010; 12/15/22

**TRANSPORTATION, MISSOURI DEPARTMENT OF**

highway safety and traffic division  
approval; 7 CSR 60-3.010; 6/15/22, 11/15/22  
approved motorcycle training courses; 7 CSR 60-1.060; 10/17/22  
approval procedure; 7 CSR 60-2.020; 6/15/22, 11/15/22  
breath alcohol ignition interlock device security; 7 CSR 60-2.050; 6/15/22, 11/15/22  
definitions; 7 CSR 60-1.010; 10/17/22  
7 CSR 60-2.010; 6/15/22, 11/15/22  
device suspension and decertification; 7 CSR 60-2.060; 6/15/22, 11/15/22  
motorcycle instructor; 7 CSR 60-1.030; 10/17/22  
motorcycle training school; 7 CSR 60-1.020; 10/17/22  
motorcycle training school instructor; 7 CSR 60-1.030; 10/17/22  
motorcycle requirements; 7 CSR 60-1.070; 10/17/22  
notice and hearing requirements; 7 CSR 60-1.080; 10/17/22  
program sponsor; 7 CSR 60-1.020; 10/17/22  
quality assurance visits; 7 CSR 60-1.100; 10/17/22  
responsibilities of manufacturers; 7 CSR 60-2.040; 6/15/22, 11/15/22  
sponsor pre-suspension notification; 7 CSR 60-1.110; 10/17/22  
sponsor suspension; 7 CSR 60-1.090; 10/17/22  
standards and specifications; 7 CSR 60-2.030; 6/15/22, 11/15/22  
student admission requirements; 7 CSR 60-1.040; 10/17/22  
verification of course completion; 7 CSR 60-1.050; 10/17/22  
Missouri highways and transportation commission  
administration; 7 CSR 10-17.030; 10/17/22  
appeals; 7 CSR 10-25.090; 7/15/22, 12/15/22  
application for international fuel tax agreement license; 7 CSR 10-25.071; 7/15/22, 12/15/22

apportion registration pursuant to the international  
registration plan; 7 CSR 10-25.030; 7/15/22, 12/15/22  
definitions;  
7 CSR 10-17.020; 10/17/22  
7 CSR 10-25.070; 7/15/22, 12/15/22  
investigation and audits; 7 CSR 10-25.080; 7/15/22, 12/15/22  
logo signing; 7 CSR 10-17.050; 10/17/22  
oversize/overweight permits; 7 CSR 10-25.020; 8/15/22  
requirements for tourist oriented directional signing;  
7 CSR 10-17.040; 10/17/22  
skill performance evaluation certificates for commercial  
drivers; 7 CSR 10-25.010; 7/15/22, 12/15/22  
subpoenas; 7 CSR 10-1.020; 7/15/22, 12/15/22  
traffic generators; 7 CSR 10-17.060; 10/17/22  
motor carrier and railroad safety  
application for a self-insurer status; 7 CSR 265-10.035;  
7/15/22, 12/15/22  
marking of vehicles; 7 CSR 265-10.025; 7/15/22, 12/15/22  
records of the division; 7 CSR 265-10.017; 7/15/22, 12/15/22

## **Rulemaking Classes**

**Are you new to rulemaking or in need of a refresher course to assist you in filing rules or understanding the rulemaking process?**

**The Administrative Rules Division offers group and individual classes for rule drafting and preparation of rule packets. Please call Curtis at (573) 751-2022 or email [curtis.treat@sos.mo.gov](mailto:curtis.treat@sos.mo.gov) to schedule a class.**

***We offer both in-person and virtual classes.***

## **Administrative Rules Contact Information**

### **General Inquiries**

(573) 751-4015  
rules@sos.mo.gov

#### **Curtis W. Treat, Editor-in-Chief**

(573) 751-2022  
curtis.treat@sos.mo.gov

#### **Stephanie Martin, Managing Editor**

(573) 522-2196  
stephanie.martin@sos.mo.gov

#### **Jacqueline D. White, Publication Specialist II**

(573) 526-1259  
jacqueline.white@sos.mo.gov

#### **Vonne Kilbourn, Editor II**

(573) 751-1818  
vonne.kilbourn@sos.mo.gov

#### **Jennifer Alex Moore, Editor**

(573) 522-2593  
jennifer.moore@sos.mo.gov

#### **Tammy Winkelman, Administrative Aide III**

(573) 751-4015  
tammy.winkelman@sos.mo.gov